MANUAL FOR STATE MEDICAID AGENCY MONITORING OF PSROs

REPORTS
RA
399
A3
M36
1979

RA
399
.A3
M36
1979

REVISED
MANUAL FOR STATE MEDICAID AGENCY
MONITORING OF PSROs

Developed under the project to
Design Methodologies and Guidelines for
States' Use in Monitoring PSRO
Review of Medicaid (Title XIX) Programs
as a joint effort between the
HEALTH STANDARDS AND QUALITY BUREAU
and the
BUREAU OF PROGRAM OPERATIONS

This project is funded by
CONTRACT NO. HSA 240-75-0015
with the
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Prepared by:

KAPPA SYSTEMS, INC.
1501 Wilson Boulevard
Arlington, Virginia 22209

Assisted by:

SYSTEMETRICS, INC.
7910 Woodmont Avenue
Bethesda, Maryland

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

TABLE OF CONTENTS

		Page
1.	INTRODUCTION	1
2.	GENERAL CONSIDERATIONS IN PSRO PERFORMANCE MONITORING	3
3.	MODEL APPROACH TO MONITORING PSRO PERFORMANCE	6
	3.1 Introduction	6
	3.2 Concept of Performance	7
	3.3 Measures of Performance	7
	3.4 Expectations of Performance	10
	3.5 Analytic Approach for Monitoring	10
	3.6 Monitoring Based on Data Collection from PSRO Management Information System	23
	3.7 Monitoring Based on Information Gathered Through Claims Review Process	40
4.	CONCLUSION	62

APPENDIX A SRS AT 76-140

APPENDIX B SRS AT 76-141

APPENDIX C MSA AT 77-43

APPENDIX D BQA General Memorandum 15-77

APPENDIX E HCFA AT 78-61 (MMB)

APPENDIX F Selected Detailed Diagnosis Related Groups

APPENDIX G Selected Procedures with Diagnosis Related Groups

APPENDIX H Diagnosis Related Groups Used in PHDDS Reports Detailed List of Included Codes

INTRODUCTION

As the Professional Standards Review Organization (PSRO) program has matured, its orientation has shifted from a broad scale concurrent review to focused review. This shift has caused concern among the State Medicaid agencies that not only is a non-State agency (the PSRO) making medical necessity decisions which may pose a threat to the fiscal integrity of the Medicaid programs, but also that the shift toward focused review is not as adequate as the former Medicaid utilization review program. These concerns have been expressed most strongly by States with the larger Medicaid programs, many of which have laboriously developed their own utilization review systems to control program costs.

Since costs of the Medicaid program are of concern to the Federal government as well as to the States, both parties share a common interest in ensuring that health services provided under Title XIX programs are appropriate to the needs of recipients. It is with both of these concerns in mind that the 1972 Amendments to the Social Security Act included provisions for professional standards review. These provisions stipulate that it is the responsibility of PSROs to determine that services rendered to Medicaid recipients are medically necessary, quality oriented, and appropriate. It is desirable, therefore, for States to be able to monitor the performance of PSROs within their boundaries in order to effectively determine what impact PSRO review has had on utilization of services and resulting State expenditures. Prior to initiating monitoring activities, States are required to submit their monitoring plans to HEW Regional Offices for approval.

It is the purpose of this manual to provide a framework for State Medicaid agencies to use in developing their PSRO monitoring plans. Because each State's Medicaid program is different, particularly in terms of the types of data available for monitoring, it has not been possible to define in detail a single PSRO monitoring system. Instead, the manual provides a generic monitoring plan and defines general performance measures, data requirements, and resource needs for program monitoring with the idea that each State will use these suggestions in constructing a PSRO monitoring system which suits its particular needs and meets

its overall resource constraints. This generic approach represents an effort on the part of the Bureau of Program Operations (Medicaid program)* and the Health Standards Quality Bureau (PSRO program) to generalize from the monitoring activities already in use by single State agencies. Those States having a Medicaid Management Information System (MMIS), are encouraged to develop a monitoring approach which is coordinated with the data outputs from that system. It is recognized, however, that each State will have to tailor this model approach to meet its particular needs, and will have to spend some time in setting up the operational details required to actually implement a monitoring program.

Although State Medicaid agencies are encouraged to develop their own approaches to monitoring, this document offers a structural framework and accompanying technical implementation guidelines for the development of PSRO monitoring plans. In addition, it provides potential performance measures for legitimate monitoring activities. Chapter 2 sets forth the conceptual context within which a monitoring system should be developed. Chapter 3 provides a summary definition and outline of a monitoring plan, as well as the technical content of suggested performance measures. States and PSROs should review SRS-AT-76-140 and 76-141, MSA-AT-77-43, BQA General Memorandum No. 15-77, and HCFA AT-78-61 (MMB) for a more thorough discussion of the process States should follow in submitting their monitoring plans to the Department, and the responsibility PSROs and health care facilities have in reviewing such monitoring plans before they are implemented. These documents are included as appendices to this manual.

*As a result of the 1979 reorganization of the Health Care Financing Administration, the Medicaid and Medicare Bureaus are now a part of the Bureau of Program Operations.

GENERAL CONSIDERATIONS IN PSRO PERFORMANCE MONITORING

State agencies and PSROs are encouraged to work together on the development of a monitoring plan, and PSRO comments on the State's proposed plan should be an integral part of the State monitoring plan submission. This approach will be helpful to both parties and will aid in the development of a working relationship between the PSRO and State agency. To achieve mutual goals, the PSRO must recognize that the purposes and objectives of State monitoring of PSRO activities include the following:

- Determine if PSRO review is being carried out appropriately.
- Ensure that State and Federal funds for institutional health care are being appropriately spent for necessary and quality care.
- Identify areas of concern which should be addressed by the PSROs, States, and/or DHEW.
- Determine whether PSRO review has affected utilization of services and expenditures of funds either positively or negatively.

Thus monitoring offers a mechanism for routine communication between the two agencies for transferring information necessary to identify potential problems so that corrective action can be taken early. For the Medicaid agencies, regular monitoring thus serves as an early warning system for problems or potential problems, which, if appropriate action is taken, improves and assures the continuing quality of PSRO review.

The Monitoring System Should Focus on Results

The main concern of the State is to ensure that the PSRO is effectively controlling utilization of services, not to oversee procedures being used by the PSRO to do its review. The monitoring system should therefore focus on key

utilization indicators such as admissions, length of stay, and total days of stay per thousand. If the monitoring system determines that these performance measures are meeting previously defined standards, further examination is not necessary. Further investigation of the actual process of review is only indicated when results are out of line with the standards. Such an "exception based" concept will minimize the costs of monitoring, will ensure that the impact on program costs can be determined, and will improve PSRO review activities.

The Monitoring Process Should Be Objective

To the maximum extent possible, the State should rely on written criteria for evaluating PSRO performance to minimize the role of subjective, individual assessment which can vary from person to person and from time to time. Uniformity of judgment will have great value to State administrators over time, as they will be able to ensure that "changes" on PSRO performance are real and not a function of different evaluators. Consistency will also ensure smooth relationships with the PSROs, who will know in advance the criteria against which they are evaluated. It will also minimize the likelihood of unresolvable disputes with PSROs by ensuring that information is clear and unambiguous. It is recognized, of course, that some subjective components may be required — medical judgment, for example — but the guiding philosophy should be to remain objective whenever possible.

The Monitoring System Should, to the Maximum Extent Possible, Be Built upon or Integrated with Existing Mechanisms in the State Medicaid Program

Every State is very likely already carrying out a number of activities that can usefully be integrated into a performance monitoring system. Such activities could include claims review (manual or automated), physician consultant referral networks, utilization analysis and monitoring, claims investigation, and a variety of others. By taking advantage of the functions already being performed in these areas, the monitoring system can be more smoothly integrated into the existing organization and can be conducted at lower incremental cost than if it is developed and implemented as a completely separate activity.

The Monitoring System Should be Completely Designed and Accepted Prior to Implementation

Prior to initiation of monitoring activities, State Medicaid agencies are required to submit for approval a detailed description of their monitoring plans. The plans should be accompanied by comments from those PSROs whose performance will be monitored and from hospitals affected by this effort [SRS-AT-76-140 (MSA)].

The Memorandum of Understanding (MOU) between a State and its PSRO(s) should indicate whether State monitoring of PSRO activity will occur. However, the MOU signed by a PSRO and State agency need not uniformly provide specific information in regard to the State monitoring plan. The Health Standards and Quality Bureau has recommended that the agreements contain only a reference to the monitoring plan. All specifications should be provided in the plan itself, which, following DHEW approval, will be attached as an appendix to the MOU. For a monitoring approach to be effective in achieving specified objectives, States and PSROs must work closely together. It can be expected that if cooperative relationships have been established, any problems which are identified will be readily resolved.

In summary, the plan must be comprehensive; the mechanics of operation must be outlined in detail with the tools of measurement well developed. The goals and objectives of the monitoring plan must be established with a detailed justification of why the approach is suitable to the State's particular needs. The monitoring concept under which the State is operating and its purpose must be described. The actual mechanics of operation and the process to be followed must be explained. The criteria for review or the standards against which the PSRO will be reviewed must be set forth. Utilization of the findings from monitoring and resolution of differences through the complaint system must be described. The methodology or techniques to be utilized in analyzing the data must be identified. The plan must detail the statistical indicators and measure the range of impact. The sampling framework should indicate the actual number of reviews, in addition to percentages.

3

MODEL APPROACH TO MONITORING PSRO PERFORMANCE

3.1 INTRODUCTION

Irrespective of the monitoring approach used or type of data collected, there are certain basic components which must be addressed in a monitoring plan. After examining the kinds of data and systems available for monitoring PSROs in a variety of States, and after examining approaches to monitoring developed by States which seem representative of the universe of Medicaid programs, it was found that many States had difficulty in developing and implementing their monitoring plans. Thus, a generic framework has been developed as a general guideline.

Monitoring PSRO performance requires that the concept of performance be operationally defined. Performance criteria must be identified. These criteria should be calculated from available data sources with a reasonable certainty as to their validity and reliability. In addition to the specification of the criteria, it is important to develop the monitoring process in which the performance measures are routinely calculated and routinely compared to previous performance assessments in order to ascertain the relative change in PSRO performance. It is also important that targets or cutoff values be set for the more critical elements of performance so that the monitoring system can recognize the types of changes that will initiate, or suggest the need for, a more in-depth review of PSRO performance. In this section, the concept of performance is discussed, measures of PSRO performance are recommended, analytical techniques are presented, potential data sources are described, and the suggested technical framework of the monitoring process is reviewed.

It is not the purpose of this framework to prescribe a system for Medicaid agencies to use in monitoring PSRO performance. Rather, the material presented here is to be used as a guide and as assistance to the agencies in developing their own monitoring plans based on State objectives, resources, and constraints.

3.2 THE CONCEPT OF PERFORMANCE

Performance must be defined in terms of the shared goals and objectives of the State Medicaid program and the PSRO. Coordination and understanding of this crucial problem of establishing common goals and objectives will frame the State's concept of monitoring. The following four tasks provide for this coordination:

Task 1: Establish overall agency goals and objectives.

Task 2: Establish Medicaid monitoring goals and objectives.

Task 3: Communicate to PSRO projections based on goals and objectives.

Task 4: Obtain PSRO feedback, revise projections, negotiate if necessary.

If this initial part of the monitoring process is successful and common goals and objectives can be established in terms of the quantity of services to be delivered to the Medicaid population, the level of services to be provided, the quality of the services, and the Medicaid program costs to be incurred, then there is a basis for defining performance and developing specific evaluative measures.

With this understanding, performance is defined as follows:

> PSRO performance is the operation of the review system to identify and take corrective action where it is found that the standards of care are not being met such that the overall practice patterns of physicians and institutions and the use of services by Medicaid eligibles within the State become, over time, more consistent with the statewide goals and objectives of Medicaid program utilization, quality, and expenditures. It is recognized that changes that occur in patient utilization and provider practice patterns may or may not be the result of PSRO activity. Therefore, it is important to the concept of performance that the cause and effect relationship between PSRO functioning and utilization and expenditure changes be assessed and that attribution and inference be carefully made.

3.3 MEASURES OF PERFORMANCE

It is the intent of the monitoring system, as described in the introduction to the manual, to focus on outcomes of PSRO activities. Therefore, the performance measures described here are not a process evaluation of the PSRO review system or internal PSRO management. Rather, the Medicaid agencies are

encouraged to examine the outputs of the health care delivery system — utilization of services, quality of care, and levels of expenditures to assess performance.

The following general performance measures are recommended for consideration by the Medicaid agency. The measures are grouped in the topics of utilization, program expenditures, and quality of care. Subsequent discussion in the analytic approach section of this chapter describes how these measures are to be used in the overall monitoring framework.

Utilization Measures

- Discharge Rate — The discharge rate is defined as the number of Medicaid discharges from acute, short-term hospitals in a given period of time (quarter, year) divided by the population eligible for Medicaid benefits during the same time period.

- Days of Care Rate — The days of care rate is defined as the number of days of care provided to Medicaid patients discharged from acute, short-term hospitals in a given time period divided by the population eligible for Medicaid benefits during the same time period.

- Average Length of Stay — The average length of stay is defined as the number of days of care provided to Medicaid patients divided by the number of Medicaid discharges.

- Preoperative Average Length of Stay — This length of stay measurement is the average number of days in the hospital prior to surgery for patients with a surgical procedure during their hospital stay.

Expenditure Measures

- Expenditures per Discharge — The expenditures per discharge are defined as the Medicaid program expenditures for acute, short-term hospitals by the State for a given period of time divided by the number of discharges for the same period.

- Expenditures per Day of Care — The expenditure per day is the Medicaid program expenditures divided by the number of days of care provided to Medicaid patients discharged during the same time period.

- Expenditures per Capita — This measure is the Medicaid program expenditures during a given time period divided by the population eligible for Medicaid benefits during the same time period.

- Percent of Expenditures for Ancillary Services — The proportion of total expenditures that are for ancillary services is calculated by dividing the amount of paid claims that are for ancillary services (nonroom and board) by the total Medicaid program expenditures for acute, short-term hospitals during a given period of time.

Quality of Care Measures

- Proportion of All Patients Discharged Dead — This measure is calculated from the utilization data and provides an assessment of the risk of mortality for patients admitted to hospitals within the PSRO's area of responsibility.

- Proportion of All Patients Readmitted — The readmission percentage is another utilization based quality of care indicator calculated by dividing the number of patients readmitted to the hospital for a problem related to a previous episode of hospitalization divided by the total number of admissions during the same time period.

- Proportion of All Patients Having Procedures That Have Been Identified as Outmoded, Ineffective, or Unnecessary by a Responsible Professional Association — Several surgical and nonsurgical procedures have been identified by professional groups as generally outmoded, ineffective, or unnecessary. This measure assesses the percentage of patients receiving these procedures as a negative indicator of quality of care in the PSRO area. For example, it is possible to examine the ratio of the above knee amputations to below knee amputations. Below knee amputations are considered a better surgical technique because of considerations in future fitting and use of prosthesis by the patient. Therefore, a higher ratio would indicate a potential problem in the quality of care with respect to this type of procedure.

It should be noted that the measures are based for the most part on aggregate utilization data that are generally available in computerized hospital discharge abstract systems and in claims payment systems.

The list of measures presented previously is not meant to be exhaustive. It is suggested as a useful overall assessment of PSRO performance when used in conjunction with the analytic approach described in the subsequent section.

3.4 EXPECTATIONS OF PERFORMANCE

In order to conduct a meaningful monitoring activity, the Medicaid State agency must translate the goals and objectives previously discussed into specific performance expectations or standards for the PSRO program with regard to Medicaid eligibles. The goals and objectives should be converted into specific performance objectives having two important attributes:

- The objectives must be quantified in terms of the utilization, expenditure, or quality of care measures previously described. For example, the objective for the discharge rate may be stated as "200 discharges per 1,000 Medicaid eligibles."

- The objectives must have a time frame. For example, the discharge rate for Medicaid eligibles will decline to "200 discharges per 1,000 Medicaid eligibles in 1980."

When the performance measures have been selected and the Medicaid program objectives have been quantified and a time frame specified for achieving the objectives, the monitoring system is ready for implementation.

3.5 ANALYTIC APPROACH FOR MONITORING

The analytic approach to monitoring is central to the functioning of the monitoring system. It specifies the measures to be examined and for what purpose, the comparisons to be made, the statistical techniques to be applied to the data to test for the presence or absence of significant differences, and the output formats for the analysis.

Levels of Disaggregation

A major decision to be made in the development of the analytical approach concerns the alternative types and levels of disaggregation that are possible within the monitoring framework. Three types of potential disaggregations are discussed below:

- By Geographic Area — If the State has more than one PSRO, it will be important to conduct the analysis and monitoring for each PSRO separately since the PSROs may differ substantially

in their performance. This disaggregation will require the specification of what counties and institutions are included in each PSRO's area of responsibility.

In a statewide PSRO or a PSRO that has a large geographic area, it may be advisable to break the PSRO area into two or more subareas to investigate differences in performance within a PSRO area.

- By Diagnosis or Procedure — The monitoring system should have the capability to disaggregate the utilization and, if possible, the expenditure data by diagnosis and procedures. It is not the intent of the monitoring system to examine the utilization trends or program costs of each diagnosis or procedure. However, the system should be able to identify a specific diagnosis or procedure of interest that may be suspected of misutilization and track its utilization trends on an exception basis.

- By Institution — The third type of disaggregation that is possible within the monitoring approach recommended here is the ability to identify and study changes in utilization, program expenditures, and quality of care at the individual institution level. As with diagnosis and procedure disaggregations, it is recommended that the institution specific analysis be performed only on an exception basis.

Comparisons

In order to monitor the performance of the PSRO using the measures specified above, three types of comparisons may be made by the Medicaid agency to gain insight into the dynamics of changes affecting Medicaid utilization, program expenditures, and quality of care. These comparisons are:

- Comparison of the actual performance level of the PSRO to the expected (or standard) level of performance. For example, the actual days of care rate may be compared to the projected days of care rate for the State.

- Comparison of the actual performance of the PSRO in a current time period to the performance in an earlier time period. For example, the actual average length of stay in the current year may be compared to the average length of stay in a baseline period to determine the trend in utilization as measured by this variable.

- Comparison of the actual performance of the PSRO to performance of other PSROs either within or outside of the State to assess the extent to which differences in performance levels occur.

Each of these three principal types of comparisons will provide the Medicaid agency with different aspects of a PSRO performance assessment. The first approach, or comparison to standards or projected levels of performance, will assess the extent to which the PSRO program is meeting the goals and objectives established by the Medicaid program for the Medicaid eligible population. The second approach, a longitudinal study of comparisons over time, provides valuable information on the trends in utilization, expenditures, and quality. Using this comparison approach it is possible to examine, for example, whether or not the PSRO program was more effective in reducing utilization in recent years than in previous years. The third approach is particularly helpful to assess the extent of differences among PSROs in a multi-PSRO State. In this case, it will be important for the State to assess the relative performance of the PSROs and identify those PSROs whose performance is not satisfactory based on the established goals and objectives.

Analytic Techniques

When comparisons are made and differences are detected, it becomes important to determine whether or not the differences are significant. However, significance can have many interpretations. A difference in a discharge rate, for example, may or may not be either statistically significant or programmatically significant. Very small differences in some measures that may have little or no statistical significance may be programmatically significant in terms of the impact of the observed variation on the financial resources of the Medicaid program. On the other hand, a statistically significant change in another selected measure may not be significant from the standpoint of the program.

If the analyses of PSRO program performance are based on the complete utilization data for the Medicaid program, a case may be made that statistical significance is not an issue. Any difference that is detected is the true difference and, since the measurement is not made using a sampling process, statistical significance is not relevant. However, the utilization, expenditures, or quality of care measures may be viewed as observations extending over time, and as such are samples of an extended process. While it is not critical to the monitoring system to resolve these two points of view, it is recommended that all comparisons be subjected to statistical tests to assess the statistical significance of any differences detected.

Several analytic techniques may be applied to the data. It is recommended that the analysis approach be as straightforward and descriptive as possible. The use of an appropriate data display is important. For presentation of rates or proportions, both the numerator and denominator values as well as the rate or proportion calculated should be presented so that the derivation of the measure is apparent as shown in Exhibit 3-1.

For the comparison of the actual performance of the PSRO to the expected utilization and expenditures experienced by the Medicaid program, the actual and projected values should be presented and the differences calculated as shown in Exhibit 3-2. The actual values may also be shown as a percentage of the projected values.

In the comparison of performance over time, a graph of the values is helpful to examine the pattern of change and assess the amount of fluctuation experienced by the performance measure under investigation. If sufficient observations over time are available, generally three years with quarterly observations, a best fit line may be calculated using a least squares technique. The slope of the best fit line will give the average change in the measure per unit time over the period. A t-test on the value of the slope may be used to determine if the slope is statistically significant from zero. Exhibit 3-3 presents an example analysis table for examining the trends over time in selected utilization measures. It is also possible, of course, to compare the value of a measure in some baseline period to the actual value in, for example, the most recent year. Since only two periods are being compared the trend analysis described above cannot be performed. However, a t-test can be used to test the statistical significance of the difference of the means between the two periods for measures such as length of stay which are based on multiple observations in each period. The z-test would be used to test the difference between rates for the two periods.

The third type of comparison included in the analytic approach is the comparison of the utilization measures among PSRO areas. Differences between two areas may be tested using the t-test or z-test depending on the type of performance measure considered.

Identification of Outliers

The outcome of the performance assessment using the aggregate statistical data available and the comparison techniques described above will result in the State Medicaid agency determining that the PSRO is either meeting or not meeting the performance goals and objectives previously set. If it is determined that, overall, the PSRO is not meeting the goals and objectives, the analytical strategy of the monitoring system must be extended to identify the reasons that the goals and objectives are not being met and what components of the acute care system

Exhibit 3-1: Discharge Rate, Days of Care Rate,
and Preparation of Patients Discharged Dead by PSRO Area

PSRO AREA	(a) No. of Discharges	(b) No. of Days of Care	(c) No. of Patients Discharged Dead	(d) No. of Medicaid Eligibles	(a/d) Discharge Rate	(b/d) Days of Care Projected	(c/a) Proportion of Dead Discharges
A							
B							
C							
D							
Subtotal							

Exhibit 3-2: Actual and Projected Values
for Medicaid Discharge Rate, Days of Care Rate, and Expenditures Per Capita

PSRO AREA	ACTUAL			PROJECTED			DIFFERENCE (actual - projected)			RATIO (actual/projected)		
	Discharge Rate	Days of Care Rate	Expenditures Per Capita	Discharge Rate	Days of Care Rate	Expenditures Per Capita	Discharge Rate	Days of Care Rate	Expenditures Per Capita	Discharge Rate	Days of Care Rate	Expenditures Per Capita
A												
B												
C												
D												
Subtotal												

Exhibit 3-3: Selected Utilization Measures by Quarter
1977 - 1979 and Characteristics of the Trends

MEASURE	1977				1978				1979				Intercept	Slope	T-Test	Probability
	1	2	3	4	1	2	3	4	1	2	3	4				
Discharge Rate																
Average Length of Stay																
Days of Care Rate																

are not consistent with the Medicaid agency projections. This is the process of identifying "outlier" diagnosis and procedure groups, geographic areas, or individual institutions that experience aberrant utilization, expenditure, or quality of care patterns based on comparison with the norm or standards set by the Medicaid agency and the PSRO. This analysis may be performed by using the performance measures, or slight modification of the measures, at the alternative levels of disaggregation discussed in a previous section of the analytic approach.

For example, if it is determined that the Medicaid utilization in the PSRO area is exceeding the overall average length of stay that was projected for the year with the potential for causing an overrun in State Medicaid expenditures for the year, the monitoring strategy should seek to identify for what diagnosis groups, for what geographic areas, and for what specific institutions the average length of stay exceeds the expected value. This may be done, in the case of the identification of institutions, by inspecting the distribution of average length of stay for the institutions in the PSRO area to determine if a few specific hospitals have relatively high average lengths of stay driving up the average or if all institutions are somewhat high. If only some institutions are high, the monitoring system can identify them and the Medicaid agency can discuss the problems with the PSRO and develop a joint plan for corrective action.

Other indicators can be used to flag hospitals, diagnosis groups, or geographic areas as potential outliers that are causing the PSRO not to meet the performance goals and objectives. Some indicators may be more important than others to the Medicaid agency and the emphases may change over time. In any case, it is possible using the aggregate statistical data available from PHDDS or claims data systems to identify outlier situations that warrant close, more extensive investigation by the Medicaid agency and the PSRO. The investigation of outliers may include many strategies from the more detailed evaluation of the institution's statistical data to the initiation of concurrent review of a sample of Medicaid cases in the outlier institution. Thus, the monitoring strategy should have the capability to reassess the performance of the systems on a periodic basis and remove institutions or PSROs from the outlier or exception status, as detailed in SRS-AT-76-140, the Complaint System shown in Exhibit 3-4.

Additional Issues and Adjustments

There are several additional issues that should be dealt with in the development of the analytic approach for the monitoring system. These issues are:

- specification of a consistent denominator of the Medicaid eligible population for use in the rate calculations;

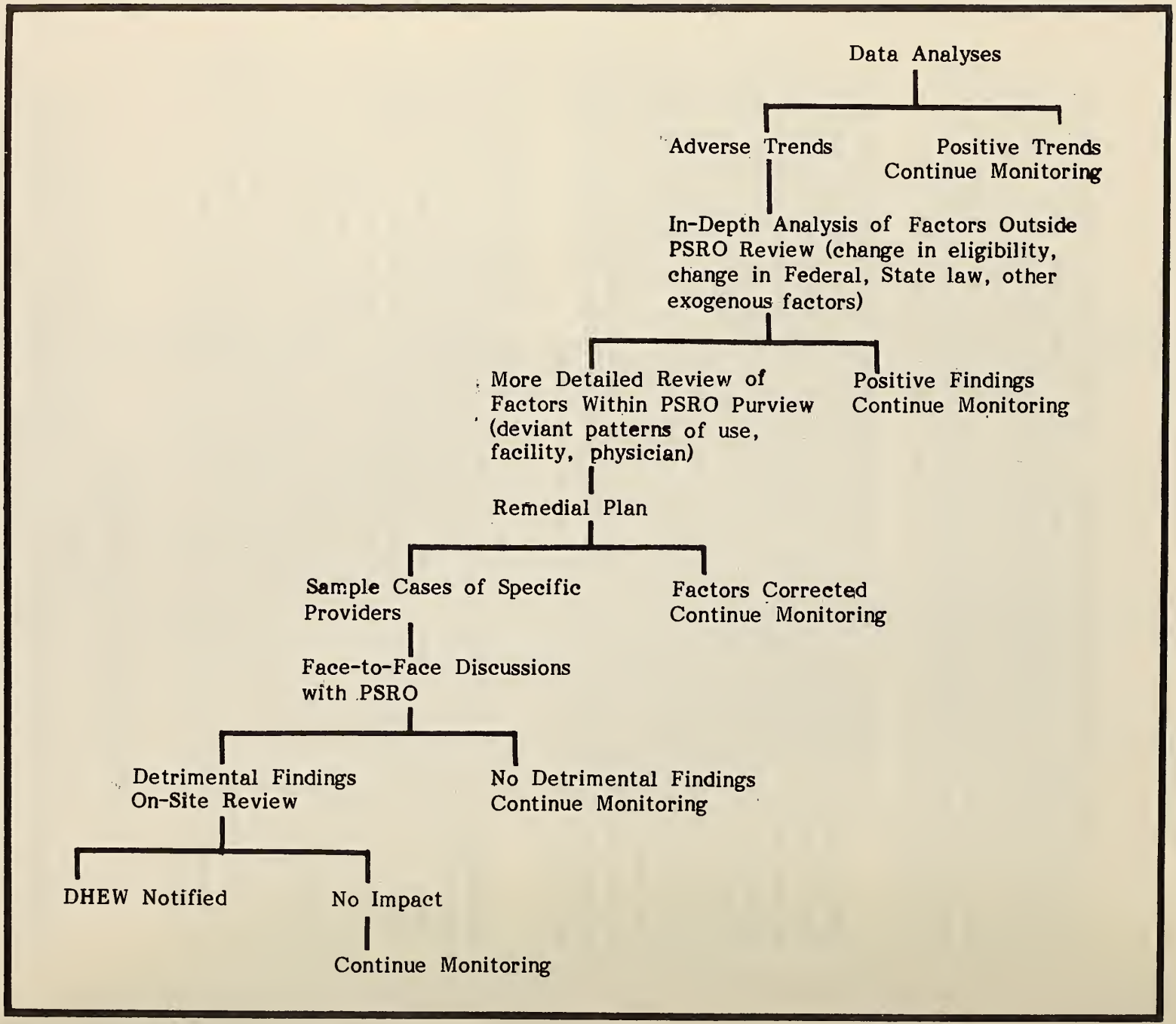
Data Analyses
Adverse Trends
Positive Trends
Continue Monitoring
In-Depth Analysis of Factors Outside PSRO Review (change in eligibility, change in Federal, State law, other exogenous factors)
More Detailed Review of Factors Within PSRO Purview (deviant patterns of use, facility, physician)
Positive Findings
Continue Monitoring
Remedial Plan
Sample Cases of Specific Providers
Factors Corrected
Continue Monitoring
Face-to-Face Discussions with PSRO
Detrimental Findings
On-Site Review
No Detrimental Findings
Continue Monitoring
DHEW Notified
No Impact
Continue Monitoring

Exhibit 3-4

- in-and-out migration patterns of patients;
- adjustments for differences in and changes over time in the age-sex distribution of the Medicaid eligible population;
- adjustments for changes in the case mix of the patient population; and
- influence of exogenous factors in Medicaid utilization and program expenditures.

Each of these issues is discussed in the following paragraphs and methodological recommendations are given.

Specification of a Consistent Denominator — Estimating the number of Medicaid eligibles can be a difficult task because of the sometimes fluctuating nature of program eligibility criteria, the movement of people in and out of the program due to changes in their income status, the coordination of benefits with Medicare, and the existence in several States of a medically needy program in addition to the categorically eligible population. While the categorically eligible population is generally identifiable, the medically needy (or indigents) appear on the eligibility files only after having received services and applied for payment. Thus, it is difficult, if not impossible, to accurately estimate the population at risk for the medically needy program with information generally available to the Medicaid agency.

In the development of a stable and consistent denominator for the Medicaid population for use in the rate calculations, the following two adjustments to the eligible population estimates are recommended:

(1) Examine the proportion of eligibles in the medically needy eligibility status of the total number of eligibles. If the proportion is large (greater than 10 percent), the utilization rate calculation may be overstated because the medically needy eligibles become eligible by using services and, therefore, do not represent the population at risk. Consideration should be given to excluding the medically needy population from the count of eligibles and removing their utilization from the numerator counts. A separate analysis may be undertaken for this group.

(2) Remove Medicaid eligibles qualifying under the Old Age Assistance or equivalent category since Medicare would be their primary payer and recorded as such on the PHDDS or claims file.

After these adjustments are made, two alternatives are available for counting the number of eligibles for the population estimate:

(1) Count the number of eligibles in the Medicaid program at a specific point in time. Counts may be made for each year as of January 1, for each quarter as of the midpoint of the quarter, or for any other specific time. These types of counts are routinely available from Medicaid agency reporting systems.

(2) Count the person-years or person-months of eligibility to estimate the number of "full-time equivalent" eligibles in the Medicaid population. This approach develops a more accurate estimate of the population at risk for services for the time period. The calculation may be made by counting the total number of months each person was eligible for services during a given year. The number of person-months are then summed for all eligibles on the file. The total is divided by 12 to give the person-years of eligibility for the Medicaid population. This type of calculation is generally not available from the Medicaid agency reporting system and may require special computer programming for and processing of the eligibility files.

In-and-Out Migration Patterns of Patients — The migration pattern of patients to obtain hospital care can pose a particularly difficult methodological problem for the monitoring system when hospitals in the surrounding States are authorized to provide services to Medicaid eligibles of the State performing the monitoring. Migration patterns of patients among PSROs may also be a problem when more than one PSRO exists in a State and providers in one area draw patients who reside in another PSRO area.

In order to handle these types of problems, the monitoring system prior to making the utilization rate calculations should be able to identify the residence location of patients and perform the following adjustments to the numerator counts of patient utilization.

- Subtract from the patient discharges those discharges for Medicaid patients residing outside the State (the State's in-migration).
- To the extent that data are available from surrounding PSROs or from Medicaid claims files, add in to the patient utilization the Medicaid patients of the State that went out of State to obtain services (the State's out-migration).

- Calculate a Statewide utilization rate that excludes the in-migration of Medicaid patients living in other States and includes the out-migration of Medicaid patients.

These adjustments can generally be made using the zip code of patient residence coded on the PHDDS or the claims file.

The same type of adjustments apply for calculating rates for the PSROs located within the same State. The rate is calculated using the counts of patient discharges (or days) for patients residing in each PSRO area regardless of where they obtained service divided by the Medicaid population of the PSRO area. The in-migration to the PSRO from surrounding PSROs is excluded from the discharge (or day) count and the out-migration is included. Thus, the rate accurately measures the per capita use of hospital services by a specific population during a specific time period.

Adjustments for Differences in and Changes Over Time in the Age-Sex Distribution of the Medicaid Eligible Population — The utilization measures used in the monitoring system are known to vary substantially among age groups and by sex for the Medicaid population. In order to measure actual shifts in utilization of hospital services over time, the extraneous effects of changes in the age-sex composition within the State or within sub-State PSROs during the study period must be eliminated. Within each PSRO, utilization rates may be adjusted for age and sex differences by standardizing the rates to a single population, holding constant the age-sex structure. This may be accomplished by computing the weighted average of age-sex-specific rates, using as weights the age-sex distribution of a selected standard population. The formula for this direct standardization procedure is:

$$\text{adjusted } r^t = \sum_{a=1}^{i} \sum_{s=1}^{2} r_{as}^t \frac{P_{as}}{P} \times 1{,}000$$

where:

r_{as}^t = the PSRO utilization rate for age-group 'a', sex 's' during period 't'

P_{as} = the standard population of sex 's' within age-group 'a'

P = the total standard Medicaid population

a = age group (i groups)

s = sex (1=male; 2=female)

t = time period

The rate computed using this procedure represents the utilization rate that the PSRO would have had during that time period (t) if the age-sex structure of the population at risk had been the same as that of the standard population. The adjusted rates are only meaningful for making comparisons with rates from other time periods which have also been adjusted using the same standard population.

The characteristics of the population selected as the "standard" affects the set of adjusted rates to be compared. In the monitoring system, an appropriate standard might be the age-sex distribution of the population in the baseline year or the year that the monitoring system went into effect.

The selection of age categories is constrained by the availability of denominator population data from the Medicaid eligibility file. It is likely that special computer runs of the eligibility file will be necessary to provide the age-sex distributions necessary for the adjustment.

Changes in Case Mix of the Patient Population — In analyzing the average length of stay of Medicaid patients over time, care must be taken to examine to what extent change in ALOS at the Statewide, PSRO-wide, or hospital levels is a function of a change in the case mix. It is known that ALOS varies substantially by diagnosis group. For example, if the mix of diagnoses in a hospital changes to include patients with conditions generally requiring longer hospital stays, the overall average length of stay for the hospital will increase. The overall length of stay may still increase even if the hospital was successful in lowering the ALOS for several diagnosis specific groups.

Therefore, the monitoring system should be capable of adjusting ALOS for case mix differences between PSROs, within a PSRO over time, or among hospitals within a PSRO. This case mix adjustment may be accomplished by analytically "forcing" the proportional representation of diagnosis groups in the total case mix to be the same between PSROs over time, or among hospitals depending on the comparison to be made. With the same proportion of diagnoses any difference or change in ALOS is the result of actual differences or changes in provider practice patterns (assuming that age and sex adjustments have also been made). It is this adjusted ALOS that should be tracked and evaluated by the monitoring system.

Influence of Exogenous Factors on Medicaid Utilization and Program Expenditures — The PSRO program is obviously not the only factor influencing the utilization of acute care hospital services by the Medicaid population. A significant danger in any monitoring activity is to attribute changes to the program being monitored. The PSRO program does not determine the demand for health services nor does the program control the supply of health resources. Therefore, it is incumbent for the Medicaid agency in its monitoring activities to look for

alternative explanations for observed changes in Medicaid program utilization and expenditures. Alternative explanations may include changes in the morbidity of the population, changes in the supply of health care resources (physicians, facilities, equipment), changes in the Medicaid benefit structure, shifting consumer preferences, and other federal or State programs (such as health planning and hospital rate setting) designed to effect the utilization of the health care system.

The Medicaid agency must also be able to quickly and thoroughly follow-up on the results or findings from its monitoring activities with additional analysis and insightful evaluation in an effort to assist the PSRO in meeting the goals and objectives shared by the PSRO program and the Medicaid agency.

The following sections describe two monitoring approaches, one using data gathered through the PSRO Management Information System, the other utilizing information from the Medicaid claims review process. It is thought that these two approaches will demonstrate the guidelines at work.

3.6 MONITORING BASED ON DATA COLLECTION FROM PSRO MANAGEMENT INFORMATION SYSTEM

For States with interest in analyzing data produced by a system external to their own operations, the PSRO Management Information System (PMIS) produces summary reports on PSRO activity within each State. The PMIS is the focal point through which data are collected, processes analyzed and reported back to managers responsible for PSRO related activities. This system provides information about the PSRO program to persons responsible for its operation, coordination, management, and evaluation. The PMIS is intended to provide the necessary management feedback to the local PSROs in addition to meeting the data requirements of DHEW, the National Professional Standards Review Council, States, and other Federal agencies, and Congress.

The purposes of the Federal reporting requirements are:

- To fulfill the intent of Section 1155 (i)(1)(B) of P. L. 92-603, the 1972 Amendments to the Social Security Act, which mandates DHEW to establish Federal reporting requirements for the PSRO program.
- To provide that set of information which will both assist each PSRO to monitor and assess its activities at the local level and allow the Federal and State governments to meet their monitoring responsibilities.

- To build a data base for preparing reports which summarize review activities and expenditures of PSROs individually, regionally, and nationally.
- To allow the Federal government to obtain summary information on PSRO activities and costs which will contribute to project renewal decisions.

The data derived from the PMIS is meant to fulfill specific needs at the various levels of the PSRO program:

- At the PSROs, the PMIS will assist in:
  - managing review activities in nondelegated hospitals;
  - monitoring review activities and service utilization in all hospitals;
  - documenting efforts made to improve the medical care delivered in the PSRO area;
  - managing current operations and planning for future needs; and
  - satisfying contract or agreement negotiation and renewal requirements.
- PMIS will assist HSQB and DHEW Regional Offices in:
  - monitoring PSRO activities;
  - monitoring hospital service utilization and review cost trends and activities;
  - administering the national program; and
  - expediting the contract or agreement renewal process.
- PMIS will assist State Medicaid agencies in:
  - monitoring PSRO implementation in hospitals;
  - monitoring hospital service utilization and cost trends;
  - comparing activities and utilization trends on a Statewide basis, as well as on an individual PSRO and related hospital basis.

Components of the PMIS

The PMIS is made up of several key subsystems which when considered collectively form an integrated input/output system which continually develops with the evolution of the PSRO program.

The Federal Reports Manual is made up of six areas of reporting requirements which may be helpful to States:

- Inpatient Review Implementation Reporting — data on the number of hospitals under review and the status of administrative agreements.
- Review Summary Reports — data on the volume of admission certifications, continued stay review, physician advisor involvement in certification and continued stay decisions, length of stay and certified days approved and utilized in acute and long-term care facilities.
- Medical Care Evaluation (MCE) Study Reporting — data on the number and types of MCE studies being performed, and the status and outcome of these studies.
- PSRO Hospital Discharge Data Set (PHDDS) Reporting — data on all Federal patients reviewed by the PSRO and their delegated hospitals.
- Profile Analysis Reporting — summary of profile analysis activities which deal with review and analysis of profiles to identify and analyze patterns of health care services, with the goal of changing patterns where indicated.
- Cost Reporting — data on PSRO and delegated hospital costs by function and expenditures category.

The Grants Application and Instructions subsystem provides annual baseline data on characteristics of the PSRO area, PSRO membership status, and descriptions of plans for training, data systems, and review activities.

The monitoring system which will be presented below contains information derived solely from the Federal Reports Manual, i.e., concurrent review activity reports and PHDDS reporting from PSROs.

General Approach to Design and Use of PMIS Reports

The principal purpose in developing report formats for use by State Medicaid agencies is to establish a systematic communication link between PSROs, HSQB, and State Medicaid agencies. The proposed reports presented below would

provide summary information to persons responsible for monitoring PSRO activities. The suggested data elements would provide aggregate information about Title XIX recipients who have received inpatient services during the reporting period. The level of aggregation presented would be dependent on the type of information available to the group or organization responsible for producing the reports. For example, for a State Medicaid agency to receive a summary of review activity for all PSROs within the State, the Health Standards and Quality Bureau would be the only source of the data (except in the case of single-State PSROs, where the PSRO could provide them).

The individual PSROs would be able to provide summary information about discharges reviewed by delegation status of the PSRO's hospitals and information about days of stay. The reports, samples of which are presented below, would provide the following types of aggregate information to State Medicaid agencies:

- Degree of PSRO implementation in its area hospitals by delegation status.
- Number of Title XIX discharges reviewed during the reporting period.
- Number of days of stay.
  - Total number of acute certified days used.
  - Total days of stay.
- Average length of stay.

As was discussed above, it is envisioned that these reports will be produced on the following three levels for State Medicaid agencies' use:

(1) Statewide summary of activity for all PSROs within the State (Exhibit 3-5).

(2) Individual PSRO summary of activity by delegation status. (Exhibit 3-6).

(3) Individual hospital summary activity by PSRO area (Exhibit 3-7).

It should be emphasized that these are samples of output which are available through various components of the PMIS reporting system. Data shown in the sample exhibits and in all exhibits in this manual are not intended to represent activities in any existing PSRO.

Since these Statewide reports would have to be produced by either the States' PSROs or HSQB, standard report formats will have to be developed as part of the monitoring plan for use by State Medicaid agencies. Whatever reports State Medicaid agencies and HSQB agree should be produced, there are certain key issues which must be kept in mind concerning the inherent limitations for use of these data. These issues include the following:

- The data presented will be aggregate figures concerning numbers of discharges, days of stay and average length of stay. As such, they are gross indicators about activity within PSROs and their hospitals.
- Aggregate data can only show where differences exist between activities of individual PSROs and their hospitals as compared to one another.
- Aggregate data can only be used as a basis for formulating questions concerning these differences. They cannot answer questions as to what the differences mean, whether they are significant, or why they occurred.
- PSROs do not have the data to relate the number of inpatient days utilized by Title XIX recipients to the costs of providing these services as paid through the State Medicaid program. If State Medicaid agencies make an attempt to relate PSRO utilization data to their own cost data, the State agency must be cautioned to guard against comparison of dissimilar data, in terms of timeframe of the reports, recipient specific charge data versus aggregate utilization information, and data from partially implemented PSROs.

These types of reports could be useful to State Medicaid agencies to give agency staff an overview of what is happening in their State or in a given PSRO. The points presented above, however, outline some of the limitations in use of these data. If these reports are produced for State Medicaid agencies, they would be most appropriately utilized in conjunction with reports produced through one of the other systems presently in this manual. If other, more detailed reports are not available to State Medicaid staff, these reports can provide a framework for analyzing trends.

While each State will have to tailor these types of reports to its own needs, and work out the details of its own system, Exhibits 3-5, 3-6, and 3-7 illustrate the types of reports which could be produced through the PMIS.

Exhibit 3-5 illustrates a quarterly Statewide summary report to be prepared by HSQB. This report provides an overview of all PSRO activity within the

Statewide PSRO Concurrent Review Summary for Title XIX Discharges

Data derived from HCFA 111, HCFA 121, and PHDDS.

Quarter Ending: December 31, 1979
PSROs Reporting Title XIX Discharges
ABC PSRO
ADF Medical Care Foundation
DBR Health Care Review Organization
XYZ Foundation for Medical Care

(1) PSRO NAME	(2) Number Hospitals in PSRO Area	(3) Actual Number Hospitals Under Review	(4) Hospitals Under Review as Percent of Total Hospitals by Delegation Status			(5) Percent of Hospitals Not Under Review	(6) Total Title XIX Discharges	(7) Acute Certified Days Used	(8) Total Days of Stay	(9) Average Length of Stay
			Non	Full	Part					
ABC PSRO										
This Qtr.	23	4	8	8	0	84	8,450	43,890	44,954	5.32
FY to Date							18,720	96,222	96,595	5.16
ADF Med. Care Fdn.										
This Qtr.	10	7	20	30	20	30	26,943	164,210	165,385	6.13
FY to Date							54,724	340,501	341,478	6.24
DBR Health Care Rev. Orgn.										
This Qtr.	6	6	0	100	0	0	10,625	66,938	66,938	6.30
FY to Date							22,467	128,520	129,704	5.77
XYZ Fdn. Med. Care										
This Qtr.	42	38	24	60	7	9	17,600	102,898	103,307	5.87
FY to Date							38,963	210,431	230,607	5.42
This Quarter TOTAL	81	55				45	63,618	377,936	380,584	5.98

Exhibit 3-5

State. It focuses on three major variables, namely, degree of implementation of hospitals, number of Title XIX discharges, and days of stay. From this report the State could compare the relative activity of PSROs within the State and relate these variables to see if further analysis is required.

In the example, while the number of hospitals in each PSRO area, the degree to which review activity has been implemented, and the number of discharges reviewed differ, the average length of stay for each appears not to be significantly different. In three of the four PSRO areas, the average length of stay for this quarter is higher than for the Fiscal Year (FY) to date, a fact which may warrant further analysis. Depending on the type of detailed information which is available from other sources, the State agency could determine the significance of these data.

Exhibit 3-6 is an example of a quarterly report prepared by either the PSRO or HSQB which summarizes an individual PSRO's review activity displayed according to the delegation status of its hospitals. This report is a subset of the Statewide summary (Exhibit 3-5) and provides more detail on the PSRO's activity. In Exhibit 3-5 it was noted that XYZ Foundation for Medical Care's average length of stay had gone up in the most recent quarter. Exhibit 3-6 shows that the same PSRO has delegated 60 percent of its hospitals and that these hospitals account for nearly 70 percent of the PSRO's Title XIX discharges, and 75 percent of the total days of stay. It can also be observed that the average length of stay is 6.31 days for Title XIX discharges reviewed in delegated hospitals and 5.01 and 4.15 days in nondelegated and partially delegated hospitals, respectively. Without testing for statistical significance, the State Medicaid agency would know that delegated hospitals are different from the other two types. This difference may be attributed to many factors including the following:

- The delegated hospitals could include among them university teaching hospitals where lengths of stay are traditionally longer than in community hospitals.
- These hospitals could be highly specialized institutions whose proportionate share of seriously ill patients (ones whose length of stay would be expected to exceed norms for the area) is greater than other area hospitals.
- The fact that they are delegated may significantly impact the average length of stay if the PSRO is not training their staff or monitoring their activities in the same manner as they do for the nondelegated and partially delegated hospitals.

Other variables may also be important factors which would be able to explain these differences. The major point is that from this report alone, the

PSRO Concurrent Review Summary for Title XIX Discharges

Data derived from HCFA 111,
HCFA 121, and PHDDS.

Quarter Ending: December 31, 1979
PSRO Name: XYZ Foundation for Medical Care

(1) Delegation Status	(2) Hospitals Under Review as Percent of Total Hospitals	(3) Total Title XIX Discharges	(4) Acute Certified Days Used	(5) Total Days of Stay	(6) Average Length of Stay
PSRO Review Nondelegated (10)	24	4,675	23,225	23,362	5.01
Hospital Review Delegated (25)	60	12,190	76,758	76,970	6.31
Partially Delegated (3)	7	735	2,915	2,975	4.05
TOTALS	91	17,600	102,898	103,307	5.87

Exhibit 3-6

State Medicaid agency will not be able to determine why these differences exist, but will be provided a basis for formulating further questions.

Exhibit 3-7 is a quarterly concurrent review summary for all hospitals within a single PSRO. This report could only be prepared by the individual PSRO and/or its data processor since only they have hospital specific data. It should be noted that this report is also a subset of that shown as Exhibit 3-5. ADF Foundation for Medical Care is shown to have the greatest number of Title XIX discharges with a relatively small number of hospitals in its area. On Exhibit 3-5, its average length of stay is shown to be higher than the Statewide average (again, statistical significance is not determined). On Exhibit 3-7, it can be noted that delegation status of the hospitals does not appear to have a significant impact on average length of stay. There are, however, four hospitals whose lengths of stay are responsible for the PSRO's greater than average overall length of stay.

After this preliminary review, several hypotheses could be made about the facilities. GHI is a teaching hospital and/or inner city institution since it reported the largest number of discharges. The 6.25 average length of stay could be considered reasonable if this figure is comparable to other similar institutions. The DEF hospital is more difficult to explain since it falls in the midrange of discharges reviewed and has no other distinguishing characteristics. The PSRO's two smallest hospitals (in terms of Title XIX discharges reviewed) have average lengths of stay which are longer than those of most of the other hospitals, thus further analysis of their individual situations may be warranted. PQR Hospital has a relatively small number of discharges and is a nondelegated hospital. It may be a newly implemented hospital and the PSRO may not have fully implemented all review procedures. This type of situation could account for patients who are not identified as Title patients to be reviewed, and as a result stay in the hospital longer than would be the case is a more experienced institution. If the hypotheses prove not to be correct as to why these hospitals have longer average lengths of stay, it would then be appropriate for the State Medicaid agency to analyze the situation further, utilizing the PHDDS reports for diagnostic specific and surgical procedures data.

The PSRO Hospital Discharge Data Set (PHDDS) is a major component of PMIS reporting and is collected for all Federal discharges processed by the PSROs.* It is a unique resource that provides data at the individual patient and

---

*PSRO Hospital Discharge Data Set User's Guide by OPSRO, HSQB, HCFA, DHEW, July 1978. The User's Guide provides the following for each report in the three series: (1) a general description, (2) a detailed explanation of all report columns, (3) suggested uses of the data displayed in the report, and (4) a sample of the report format.

PSRO Concurrent Review Summary for Title XIX Discharges
(Detailed Analysis)

Data derived from HCFA 111
and HCFA 121.

Quarter Ending: December 31, 1979
PSRO Name: ADF Medical Care Foundation

(1) Hospital Name	(2) Delegation Status FD/ND/PD	(3) Total Title XIX Discharges	(4) Acute Certified Days Used	(5) Total Days of Stay	(6) Average Length of Stay
ABC Hosp.	ND	2,320	12,460	12,598	5.43
DEF Hosp.	PD	4,760	30,737	31,321	6.58
GHI Hosp.	FD	9,850	61,540	61,562	6.25
JKL Hosp.	FD	2,103	11,960	11,966	5.69
MNO Hosp.	FD	5,670	33,016	33,113	5.84
PQR Hosp.	ND	900	5,765	6,075	6.75
STU Hosp.	PD	1,340	8,732	8,750	6.53
TOTALS		26,943	164,210	165,385	6.13

Exhibit 3-7

hospital level and is the only source of data containing patient mix information, which is key to analyzing utilization patterns. The PHDDS report package includes three series of reports as follows:

- Series 1 — Summary of Utilization consists of one report which displays overall utilization patterns for all Medicare, Medicaid, and Title V discharges under review and separately for each of the three titles. The report is produced for all reporting PSROs (the Nation), all reporting PSROs in each of the four census regions, and each individual reporting PSRO. This report represents an overview of PSRO utilization experience.

- Series 2 — Utilization by Selected Detailed Diagnostic Group focuses on utilization by diagnosis group and consists of four report formats. Table 1 displays data for each of the 18 selected diagnosis groups for all reporting PSROs (the Nation) and individual PSROs. This table, shown in Exhibit 3-8, provides in-depth data on average length of stay by diagnosis group. Table 2 is a graphic display of the percentile information by diagnosis group comparing the Nation, region, and individual PSRO. Table 3 summarizes average stay data for the 18 diagnosis groups by Nation, census region, and individual PSRO indicating the extent to which the PSRO differs from the Nation or census region. Table 4 displays average stay data for the 18 selected diagnosis related groups for each hospital in the PSRO and is also shown in Exhibit 3-9. This report allows further investigation of stay patterns.

- Series 3 — Utilization by Selected Procedures shifts the emphasis to utilization patterns for operated patients and consists of four report formats. Table 1 displays average overall and preoperative stay information for all reporting PSROs (the Nation). Table 2 is a comparison of the average preoperative stay in the PSRO for 11 selected procedures, Exhibit 3-10. This report allows comparison between average preoperative stay to those of the appropriate census region and nationwide. Table 3 summarizes average preoperative stay data for the 11 selected procedures by census region and individual PSRO. The number of procedures with average preoperative stays at least 20 percent longer or 20 percent shorter than the appropriate reference group are displayed. Table 4 displays average preoperative stay data for the 11 procedures and assists investigation of preoperative stay patterns as shown in Exhibit 3-11.

UTILIZATION BY SELECTED DETAILED DIAGNOSIS GROUPS
NATIONAL REPORT, N = 77 PSROS
JANUARY - DECEMBER 1978

SERIES 2
TABLE I

SELECTED DETAILED DIAGNOSIS GROUP (1)	ALL TITLE DISCHARGES: TOTAL NO.OF DISCHARGES (2)	TOTAL DAYS (3)	DEATHS (4)	LONG STAY PTS.-1 (5)	AVERAGE STAY: STUDIED PTS.-2 (6)	AVG. STAY (7)	COEFF VAR-3 (8)	PERCENTILE STAY IN DAYS-4: 10TH (9)	25TH (10)	50TH (11)	75TH (12)	90TH (13)
DIABETES,AGE>35 W/O OP W/O 2ND DX	36425	336539	884	755	34786	8.4	0.6	3	5	7	11	16
NEUROSES,PERSONALITY DISORDERS	27444	378822	99	413	26932	12.6	0.9	2	5	9	18	30
DIS OF EYE WITH EXTRACTION OF LENS	113816	526076	234	2344	111238	4.2	0.5	2	3	4	5	7
ACUTE MYOCARDIAL INFARCTION	99639	1330110	24756	893	73990	15.0	0.5	6	10	14	19	25
ISCHEMIC HEART DIS,W/O OP W/O 2ND DX	29963	184139	742	217	29004	5.9	0.7	2	3	5	8	11
CEREB THROMBO-EMBOL W/O OP, W/O 2ND DX	22026	230553	2617	794	18615	8.9	0.7	2	4	7	13	22
HYPERTROPHY OF T & A	24804	54752	10	303	24491	1.9	0.4	1	2	2	2	3
ACUTE UPPER RESP. INF.&INFLU. AGE>44	26770	213255	549	505	25716	7.3	0.6	3	4	6	10	14
PNEUMONIA, AGE<31	31245	189054	231	475	30539	5.6	0.6	2	3	5	7	10
PNEUMONIA, AGE>30,W/O OP W/O 2ND DX	28106	234514	2275	376	25455	8.0	0.5	3	5	7	10	14
GASTRIC & PEPTIC ULCER W/O OP W/O 2ND DX	9027	55890	92	84	8851	5.9	0.6	2	3	5	8	11
HERNIA OF ABD CAV, AGE>64 W/MINOR REPAIR	44261	331568	310	1175	42776	6.8	0.5	3	4	6	9	13
DIS OF GB & BILE DUCT WITH OP,W/O 2ND DX	14733	167269	111	489	14133	10.5	0.4	6	8	10	13	18
DIS PROSTATE,W/TRANSUR PROST,W/O 2ND DX	17862	145717	42	123	17697	8.0	0.4	4	6	7	10	13
DIS OF FEM GEN ORG W/HYSTEREC,OTH MAJ OP	32223	289791	97	794	31332	8.3	0.4	5	6	8	10	14
NORMAL DELIVERY, W/O OP OR W/MINOR OP	129139	418522	61	1286	127792	3.1	0.3	2	2	3	4	4
ARTHRITIS W/REPAIR,PLASTIC OP,LAMNECTOMY	20399	414078	141	385	19873	19.2	0.4	10	14	18	24	32
FRACTURE OF FEMUR,PELVIS,MULTIPLE W/O OP	23391	363191	955	389	22047	14.3	0.8	3	7	12	20	31

1-LIVE DISCHARGES WITH UNUSUALLY LONG STAYS, WHO WOULD SKEW THE AVERAGE STAY. THE DEFINITION OF A LONG STAY IS DEPENDENT UPON THE PATIENT'S PRINCIPAL DIAGNOSIS.
2-EXCLUDES DEATHS AND LONG STAYS(COLS. 4 AND 5). THESE PATIENTS ARE ALSO EXCLUDED FROM COLS. 7 AND 8.
3-THE STANDARD DEVIATION DIVIDED BY THE AVERAGE STAY
4-EXCLUDES DEATHS ONLY.

Exhibit 3-8

PSRO XXXX

SERIES 2
TABLE 4
PAGE 1

AVERAGE STAY FOR STUDIED PATIENTS* IN SELECTED DETAILED DIAGNOSIS GROUPS
HOSPITAL DATA

JANUARY 1978 - JUNE 1978

AREA (1)	DIAGNOSIS GROUP** DIAB (2)	NEUR (3)	EYE (4)	AMI (5)	ISCH HEART (6)	CEREB THRDM (7)	T & A (8)	URI (9)	PNEUMDN <31 (10)	PNEUMDN >30 (11)	ULCER (12)	HERN ABD (13)	GB & BILE (14)	PRDST (15)	FEM GEN (16)	NDRM DEL (17)	ARTH (18)	FX FEMUR (19)
NATION	8.4	12.2	4.3	15.2	6.0	9.0	1.9	7.5	5.7	8.2	6.0	6.9	10.6	8.2	8.4	3.1	19.2	14.4
WESTERN REG.	6.6	9.0	3.4	12.3	4.4	7.3	1.7	5.8	4.9	7.1	5.2	5.1	9.0	6.2	7.0	2.5	15.5	11.9
PSRD XXXX	7.3	9.6	3.7	14.4	5.1	9.4	1.9	6.2	5.6	7.9	6.4	6.1	10.5	6.9	7.5	2.8	17.5	14.5
HOSPITALS																		
007																		
STUDIED PTS.	0	0	0	1	5	0	0	20	0	2	1	0	0	0	0	1	0	0
AVG. STAY				7.0	4.2			8.8		14.0	4.0					3.0		
014																		
STUDIED PTS.	6	3	77	6	5	0	4	5	4	2	4	14	0	9	8	4	4	4
AVG. STAY	8.7	5.3	3.1	15.2	7.0		1.8	5.2	4.0	5.5	6.8	7.9		8.4	13.8	2.5	14.8	11.5
021																		
STUDIED PTS.	24	9	150	47	32	18	3	10	0	40	4	32	22	34	12	3	21	20
AVG. STAY	7.4	6.4	3.9	14.7	4.9	10.8	2.0	5.1		8.3	5.3	4.8	11.7	7.0	6.8	3.0	21.0	19.6
028																		
STUDIED PTS.	4	3	0	5	2	3	5	9	9	2	1	3	1	0	2	8	0	4
AVG. STAY	5.8	6.0		14.8	6.5	5.7	1.0	7.6	4.3	5.5	10.0	8.7	19.0		7.5	2.4		15.0
035																		
STUDIED PTS.	4	3	125	3	2	13	4	7	4	6	0	8	0	4	3	0	3	7
AVG. STAY	4.8	6.3	3.4	18.0	2.5	13.9	1.3	4.9	2.3	6.7		5.6		5.8	6.3		12.0	16.3
042																		
STUDIED PTS.	0	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	5
AVG. STAY						18.8												21.0
049																		
STUDIED PTS.	7	2	0	16	13	6	0	5	1	19	3	12	4	10	9	29	12	11
AVG. STAY	8.6	4.5		12.8	4.4	6.0		4.8	3.0	7.2	3.3	4.3	8.0	5.3	8.7	2.6	18.5	17.5

*EXCLUDES DEATHS AND LIVE DISCHARGES WITH UNUSUALLY LONG STAYS, WHO WOULD SKEW THE AVERAGE STAY. THE DEFINITION OF A LONG STAY IS DEPENDENT UPON THE PATIENT'S PRINCIPAL DIAGNOSIS.

** DIAGNOSTIC HEADINGS REFER TO THE DIAGNOSTIC RELATED GROUPS (DRG) DESCRIBED IN SPECIFIC DETAIL IN SERIES 2, TABLES1 AND 2.

Exhibit 3-9

PSRO XXXX

SERIES 3
TABLE 2
PAGE 1

COMPARATIVE AVERAGE PRE-OP STAY FOR 11 SELECTED PROCEDURES
PSRO XXXX, WESTERN REGION AND NATION

JANUARY - JUNE 1978

PROCEDURE	PSRO XXXX TOTAL PTS.	PSRO XXXX AV.PRE-OP STAY	WESTERN REGION TOTAL PTS.	WESTERN REGION AV.PRE-OP STAY	NATION TOTAL PTS.	NATION AV.PRE-OP STAY	PSRO COMPARED TO * REGION		PSRO COMPARED TO * NATION	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)		(9)	
CHOLECYSTECTOMY										
DIS OF GB & BILE DUCT W/O DX2	220	2.5	1280	2.5	7109	3.0		0.0	-	0.5
DIS OF GB & BILE DUCT W/OX2,AGE<65	96	2.8	805	2.1	4408	3.7	+	0.7	-	0.9
DIS OF GB & BILE DUCT W/OX2,AGE>64	269	3.3	2232	2.8	12108	4.5	+	0.5	-	1.2
SUBTOTAL	585	2.9	4317	2.6	23625	3.9	+	0.3	-	1.0
OTHER DIAGNOSIS GROUPS	48	8.2	473	5.6	2510	9.3				
TOTAL DIAGNOSIS GROUPS	633	3.3	4790	2.9	26135	4.4				
HEMORRHOIDECTOMY										
HEMORRHOIDS	99	1.9	728	1.4	4781	2.0	+	0.5	-	0.1
OTHER DIAGNOSIS GROUPS	9	4.3	95	1.9	682	5.7				
TOTAL DIAGNOSIS GROUPS	108	2.1	823	1.5	5463	2.5				
INGUINOFEMORAL HERNIORRHAPHY										
HERNIA OF ABD CAV, AGE <15	43	0.8	395	0.8	2849	1.0		0.0	-	0.2
ING HERNIA W/O OB 14<AGE<65 W/O OX2	52	1.2	325	1.1	1712	1.3	+	0.1	-	0.1
HERNIA OF ABD CAV, AGE >64	576	1.4	4470	1.2	20888	1.7	+	0.2	-	0.3
SUBTOTAL	671	1.3	5190	1.2	25449	1.6	+	0.1	-	0.3
OTHER DIAGNOSIS GROUPS	57	6.7	479	3.3	3046	4.6				
TOTAL DIAGNOSIS GROUPS	728	1.7	5669	1.4	28495	1.9				
HYSTERECTOMY										
CA UTERUS-CORPUS W/ABD. HYSTERECT.	35	1.7	473	1.5	2192	2.3	+	0.2	-	0.6
CA UTERUS-CERVIX OVARY W/ABD.HYSTR	5	3.6	85	2.3	589	3.5	+	1.3	+	0.1
BEN NEOPL UTERUS,OVARY	30	1.8	297	1.3	2471	2.4	+	0.5	-	0.6
DIS FEMALE GEN. ORGANS	296	1.3	1809	1.3	8477	1.9		0.0	-	0.6
SUBTOTAL	366	1.4	2664	1.3	13729	2.1	+	0.1	-	0.7
OTHER DIAGNOSIS GROUPS	56	2.1	579	1.6	2067	2.9				
TOTAL DIAGNOSIS GROUPS	422	1.5	3243	1.4	15796	2.2				
TRANSURETHRAL PROSTATECTOMY										
CA MALE GENITAL ORGANS	170	2.8	1072	2.8	5475	4.3		0.0	-	1.5
DIS OF PROSTATE W/O DX2	447	1.9	2177	1.5	8775	2.4	+	0.4	-	0.5
DIS OF PROSTATE W/OX2	249	2.8	2469	2.3	13212	4.0	+	0.5	-	1.2
SUBTOTAL	866	2.3	5718	2.1	27462	3.6	+	0.2	-	1.3
OTHER DIAGNOSIS GROUPS	151	7.7	1253	4.9	5964	8.3				
TOTAL DIAGNOSIS GROUPS	1017	3.1	6971	2.6	33426	4.4				

*THE COMPARISION IS MADE ONLY FOR THE SPECIFIC DIAGNOSIS GROUPS AND THEIR SUBTOTAL.

Exhibit 3-10

PSRO XXXX

SERIES 3
TABLE 4
PAGE 1

AVERAGE PRE-OP STAY* FOR SELECTED PROCEDURES
HOSPITAL DATA

JANUARY 1978 - JUNE 1978

AREA (1)	CHOLE (2)	HEMOR (3)	INGUINO HERN (4)	HYST (5)	TRANS PROST (6)	SUPRA PROST (7)	T & A (8)	INTRA LENS EXTR (9)	RAD MASTEC (10)	ARTHRO PLASTY (11)	C-SEC (12)
	PROCEDURE**										
NATION	3.9	2.0	1.6	2.1	3.6	4.8	.9	1.2	2.3	2.7	.9
WESTERN REG.	2.6	1.4	1.2	1.3	2.1	2.2	.8	1.1	1.6	2.0	.7
PSRO XXXX	2.9	1.9	1.3	1.4	2.3	2.6	.9	1.0	2.1	2.3	.9
HOSPITALS											
014											
PATIENTS	6	1	14	6	20	0	3	77	1	4	2
AVG PRE-OP	2.7	1.0	1.9	2.5	3.9	0.0	0.0	1.0	3.0	1.8	0.5
021											
PATIENTS	22	2	33	12	46	1	3	142	14	27	0
AVG PRE-OP	2.2	1.0	0.9	1.8	2.4	1.0	0.7	1.1	1.6	1.4	0.0
028											
PATIENTS	0	0	4	3	0	0	4	0	0	3	2
AVG PRE-OP	0.0	0.0	0.5	1.3	0.0	0.0	0.0	0.0	0.0	2.3	1.0
035											
PATIENTS	2	0	9	1	7	0	4	113	2	3	0
AVG PRE-OP	1.0	0.0	1.8	1.0	3.4	0.0	0.5	1.0	4.5	1.0	0.0
049											
PATIENTS	8	0	14	5	13	0	0	0	6	13	11
AVG PRE-OP	2.5	0.0	1.0	1.0	1.2	0.0	0.0	0.0	1.0	2.5	0.4
056											
PATIENTS	4	1	7	1	0	0	2	17	2	1	0
AVG PRE-OP	1.0	3.0	0.7	1.0	0.0	0.0	1.0	1.0	1.5	5.0	0.0
063											
PATIENTS	15	3	12	8	12	0	5	43	1	5	4
AVG PRE-OP	3.2	1.0	1.0	1.1	1.4	0.0	0.6	1.0	1.0	1.2	0.3
070											
PATIENTS	6	1	8	2	13	0	0	7	0	8	0
AVG PRE-OP	1.7	1.0	1.0	1.0	1.5	0.0	0.0	1.0	0.0	1.4	0.0

*EXCLUDES PATIENTS GROUPED UNDER "OTHER DIAGNOSIS GROUPS" IN SERIES 3, TABLES 1 AND 2.
** PROCEDURE HEADINGS REFER TO THE SAME PROCEDURES DESCRIBED WITHIN SERIES 3, TABLES 1 AND 2.

Exhibit 3-11

From PHDDS reports, the State Medicaid agency will have comparative data which allows assessment of activity nationwide, regionally, and by PSRO area. In addition to reports on review activity, the PHDDS output reports deal with diagnosis-specific data, and could be directed at key elective surgical procedures, if necessary, to demonstrate hospital utilization controls and their effectiveness. PHDDS output reports can also present key diagnoses which account for a majority of admissions and compare PSROs (e.g., tracer diagnoses). With these reports highlighting problem areas, the State agency will then be able to focus its efforts more effectively.

Probably the most important control which has been built into the national reports is information on patient mix, which is the unique aspect of the PHDDS. Controlling for these case mix factors will increase the validity of comparisons between PSROs, regions, and other possible groupings on key utilization measures. This is nowhere more important than in the analysis of length of stay. There may be some value in comparing gross average stay over time in the same PSRO, if the assumption can be made that case mix in the hospitals involved has not changed during the relevant time period. But comparisons of lengths of stay between PSROs will not be meaningful without reference to diagnosis group.

The decision was made to focus on specific key diagnosis groups in the national profiles in order to limit the number of categories to be displayed and also to turn attention away from the less meaningful gross average stay statistics. By displaying the same categories each reporting period, trends can be observed and efforts to reduce stays, where appropriate, will become evident.

After examining various approaches for displaying diagnostic data, it was decided that the routine reports would display data for a subset of the diagnosis groups in the AUTOGRP patient classification scheme. This scheme was created through the application of AUTOGRP,* an interactive computer system, to a large data base. The scheme begins with a set of 83 broad diagnostic categories, which relate to the major body systems and have consistency in terms of their anatomical, physiopathological classification. From these broad categories a data base of approximately 500,000 hospital discharges was empirically partitioned into 383 medically meaningful groups (referred to as Diagnosis Related Groups or DRGs) with consistent and stable patterns of length of stay. In addition to patient diagnosis, the DRGs also control for a number of medically pertinent variables, such as age, presence or absence and type of secondary diagnosis and presence or absence and type of surgery performed.

---

*AUTOGRP is an interactive statistical computer system for the analysis of health care data, which was developed by the Center for the Study of Health Services at Yale University with Federal contractual support.

These variables are included in the group definition only when they have proven relevant to stay patterns by significantly reducing the variance for that group.

The specific subset of diagnostic categories studied in the reports consists of 18 Diagnosis Related Groups, which represent approximately 15 to 20 percent of the total discharges reported by a PSRO and are a cross-section of the 83 broad diagnostic categories. The 18 groups, which are described in Appendices F and H, were selected based on their relationship to conditions with high frequency, high system impact, and relatively high cost. In addition, groups were selected which were considered to have a higher level of coding reliability, based on studies of abstracted data and on medical judgment.

The national profiles also examine utilization data for a selected number of procedures as detailed in Appendix G. The 11 procedures studied were selected based on their relationship to the diagnostic conditions included in the reports or to other high frequency diagnosis groups. A number of these procedures have been the subject of studies on national and regional surgical rates and are treated in current criteria sets. The 11 procedures accounted for approximately 22 percent of the patients who had any procedure in a survey of nearly 115,000 PSRO discharges. When displaying information on procedures, the reports group the patients according to their principal diagnostic category, in order to assure that comparisons are made between similar groups of patients.

As answers to types of questions presented previously are worked out between the State Medicaid agency and its PSROs, a clearer understanding of the methods, types of activities, problems encountered and expectations of all concerned parties could be anticipated to develop. HSQB and State Medicaid agencies working through the Bureau of Program Operations will develop the types of reports which will assist States in their efforts to monitor the performance of PSROs. The situations presented above are merely hypothetical suppositions made to accomplish the following objectives:

- Demonstrate approaches to analyzing proposed PMIS based reports.
- Illustrate ways in which differences in PSROs' or hospitals' performances may be further investigated.
- Present reasonable explanation for these differences, or, in fact, highlight areas where problems actually exist.
- Integrate information from three different reports on activities of individual PSROs as found on the following levels of aggregation:
  - Statewide summary
  - Individual PSRO summary
  - Individual hospital summary.

3.7 MONITORING BASED ON INFORMATION GATHERED THROUGH CLAIMS REVIEW PROCESS

In addition to, or as an alternative to use of PMIS generated data, State agencies may choose to monitor PSRO performance through existing systems of postpayment claims review. Since the specific characteristics of these systems differ from State to State, two data collection approaches are presented. These two approaches should be considered as variations of a single model, namely, retrospective review of a sample of paid claims as follows:

- Retrospective review of a sample of claims paid by the State Medicaid agency for Title XIX recipients reviewed by a PSRO.
- Retrospective review of the total universe of claims paid by the State Medicaid agency for Title XIX recipients reviewed by a PSRO.

Either of these approaches could be implemented by the State Medicaid agency itself, or on behalf of the State by the State's fiscal agent (if applicable). The first involves retrospective review of a sample of claims. For ease of presentation, the random sample selection approach which could be implemented by the State agency will be discussed initially, followed by a discussion of a similar approach which could be implemented by the State's fiscal agent.

State Agency Review of a Sample of Paid Claims

Most States have implemented systems for retrospective review of claims submitted for inpatient service rendered to Title XIX recipients. For States who choose to monitor PSRO performance to determine the impact of PSRO review on their program, these existing systems can be utilized as the base for the PSRO monitoring system. The system which will be discussed below includes a procedural outline as well as potential data display formats to assist States in analyzing results of the claims review.

The rationale for retrospectively drawing a sample of paid claims is that it is an efficient, cost-effective method for reviewing services which have been utilized, providers who have delivered the services, and dollars which have been expended for the services. If the sample of claims is selected properly and in sufficient quantity, the results of the review should give State agency staff an accurate overview of utilization and expenditures for the period reviewed. If review of a sample of claims is conducted regularly, State agency staff will be able to perform trend analyses to determine if currently emerging patterns of utilization and expenditures are similar to those of the past. If these analyses indicate that PSRO review is either increasing or decreasing utilization of services and/or

expenditures, determination must be made to ensure that comparability exists between the periods reviewed for the eligible population, covered benefits, and provider reimbursement schedules. Further discussion on analysis of sample claims review outcomes and limitations of the data will follow presentation of the procedural process for performing review of a sample of claims. The procedural process for implementing such a system will be described below:

(1) Select a random sample of paid inpatient service claims. In the following example, seven percent has been arbitrarily selected for determining sample size. States which utilize this type of review system should select a sample size which does not exceed 20 percent of submitted claims.

(2) Screen the selected sample of claims for lengths of stay which exceed State specified norms. Claims which pass this screen, usually performed by clerical staff, are not reviewed further. Claims which fail are referred to medical specialists (such as nurses) or to physician staff for verification.

(3) Claims which fail the second review are flagged to indicate a review of the service recipient's hospital chart is indicated. The PSRO is notified at this point that a review of the record will take place, and is requested to make required arrangements.

(4) Obtain access to copies of the hospital charts and supporting data for the flagged claims to the extent permissible. These charts will be required for the review process. The PSRO can obtain copies of the chart from the hospitals, the hospital can abstract the necessary information from the charts and forward it to the State agency, or the hospital can mail a copy of the charts to the State agency if confidentiality is ensured. State agency staff can also go to the hospitals and review the charts on site.

(5) The charts are reviewed by physicians designated by the State agency to determine if the days of stay or admission were justified by the patient's condition. If further information is required, the PSRO should be contacted. If there is no further question concerning the chart, it is either returned to the hospital or the review is otherwise completed. If the length of stay or admission is judged to be inappropriate, the PSRO is notified of this determination and is requested to respond within a specified period of time. If an explanation is not forthcoming, the claim is considered to be unjustified. If the PSRO disputes the State's determination, but is unable to convince the State's reviewer that the admission and/or length of stay were appropriate,

the claim is considered to be unjustified for purposes of State agency records. It should be emphasized that PSRO review determinations concerning medical necessity are final and that claims submitted for these services (if included in the State plan) must be paid by the State regardless of whether they would have been passed by the State's own utilization review system or are considered as unjustified by the State.

(6) The State agency will maintain records on this review process. The type of information which would be tallied on a monthly, quarterly, or semiannual basis would include:

- Number of claims reviewed for excessive LOS (by hospital and PSRO area).
- Number of claims for which length of stay exceeded specified norms for the diagnostic category.
- Number of claims for which a hospital chart review was deemed to be required.
- Tally of outcome of the hospital chart reviews and PSRO responses.
- Ratio of unjustified claims to total claims submitted (by hospital and PSRO area).

(7) Periodically contact each PSRO whose ratio of unjustified claims exceeds a previously agreed upon limit. HSQB and the appropriate Regional Office should also be contacted. A meeting should be arranged between the State agency, PSRO and other interested persons to work out a mutually acceptable plan of corrective action.

Exhibits 3-12 and 3-13 present potential formats for displaying the data discussed under item 6. Exhibit 3-12 deals specifically with claims reviewed internally by the State Medicaid agency staff. Each PSRO and the hospitals for which it is responsible is separately listed. The total claims reviewed includes those included in the seven percent sample review for excessive length of stay. In this example the seven percent sample is interpreted to mean seven percent of total claims received from each PSRO during the month of December. It should be emphasized that as State agencies begin to discover, as a result of their review of the data, that problems might exist, State agency staff should immediately contact the PSRO in question. The State agency should be closely involved in all discussions which deal with these problems as soon as it has been established that a potential problem exists. If the State and PSRO work together in a cooperative spirit, the entire review and monitoring process will be more likely to proceed smoothly.

Statewide Summary of Retrospective Review of A Sample of Claims

Prepared by State Medicaid Agency

Month Ending: December 31, 1979

PSROs Reporting Title XIX Discharges

ADF Medical Care Foundation
ABC PSRO
DBR Health Care Review Organization
XYZ Foundation for Medical Care

	7% Sample of PSRO Invoices Reviewed for Excess LOS	Invoices Indicating Excessive LOS	Other	Records Reviewed
ADF Medical Care Foundation				
ABC Hospital	13	1		
DEF Hospital	14	3		2
GHI Hospital	97	20		16
JKL Hospital	9			
MNO Hospital	16	2		2
PQR Hospital	36	1		1
STU Hospital	78	8		6
Subtotal	263	35		27
ABC PSRO				
TLC Hospital	3			
ACF Hospital	5	1		
DTP Hospital	8	2		2
TUR Hospital	3	1		1
Subtotal	20	4		3
DBR Health Care Review Orgn				
YOS Hospital	16	2		1
WTB Hospital	6	1		
LNM Hospital	7	2		2
RUL Hospital	5			
TTB Hospital	6	1		1
XNI Hospital	4			
Subtotal	44	6		4
XYZ Fdn for Medical Care				
ALA Hospital	2			
KBB Hospital	12	3		2
MGB Hospital	9	2		1
SMJ Hospital	3			
Subtotal	26	5		3
TOTALS	353	50		37

Exhibit 3-12

These claims are reviewed by State agency staff for excessive lengths of stay by comparing the indicated diagnosis against State accepted norms. Those claims indicating an excessive length of stay will be reviewed by professional persons either employed by or under contract to the State agency. If questions still remain, the chart itself is reviewed.

Exhibit 3-13 is a representation of the hypothetical outcome of the review of charts questioned by State Medicaid agency representatives. This report would be produced after the charts have been reviewed and after the PSRO has responded to the State agency's inquiries about these cases. This exhibit includes the following data:

- Total number of records reviewed.
- Number of records for which the preoperative stay was determined to be excessive.
- Number of records for which the postoperative stay was determined to be excessive.
- Number of records for which a weekend admission was responsible for an excessive length of stay.
- Number of records for which the length of stay originally appeared to be excessive but was, in fact, justified by the patient's condition.
- Number of records considered justified for other reasons.
- Number of records for which an unspecified reason explains the LOS.
- Ratio of unjustified claims (total of preceding columns, excluding the LOS justified column) to total claims submitted to the State agency by the PSRO. The percentage which this ratio represents is also presented.

It is recognized that this monitoring system has limitations in that only a sample of claims are reviewed; however, there are possible variations of this system which could be initiated without too much difficulty. Two of these variations include the following:

- Select a random sample of claims from a previously screened group. Prior screening could be used to eliminate diagnostic categories for which length of stay problems rarely occur (i.e., normal child birth).

Summary of Medical Record Review Outcome

Prepared by State Medicaid Agency

Month Ending: December 31, 1979
PSROs Reporting Title XIX Discharges

ADF Medical Care Foundation
ABC PSRO
DBR Health Care Review Organization
XYZ Foundation for Medical Care

	Records Reviewed	Pre-Op Days Excessive	Post-Op Excessive	Weekend Admission Excessive LOS	Excessive LOS Justified	Other	Ratio Unjustified Claims to Total Claims
ADF Medical Care Foundation							
ABC Hospital							
DEF Hospital	2	1		1			
GHI Hospital	16	5	4	3	4		
JKL Hospital							
MNO Hospital	2		1		1		
PQR Hospital	1	1			1		
STU Hospital	6	2	2	1	1		
Subtotal	27	9	7	5	6		21:3757 [0.558%]
ABC PSRO							
TLC Hospital							
AFC Hospital							
DTP Hospital	2	1			1		
TUR Hospital	1		1				
Subtotal	3	1	1		1		2:286 [0.69%]
DBR Health Care Review Orgn							
YOS Hospital	1	1					
WTB Hospital							
LNM Hospital	2		1	1			
RUL Hospital							
TTB Hospital	1				1		
XNI Hospital							
Subtotal	4	1	1	1	1		3:629 [0.476%]
XYZ Fdn for Medical Care							
ALA Hospital							
KBB Hospital	2	1			1		
MGB Hospital	1		1				
SMJ Hospital							
Subtotal	3	1	1		1		2:371 [0.539%]
TOTALS	37	12	10	6	9		28:5043 [0.555%]

Exhibit 3-13

- Choose a specified number of diagnostic categories and select a sample of claims only from these categories. The categories could be fixed for a certain period of time and then revised to include new diagnoses.

In addition to review of a sample of claims for monitoring purposes, State agencies could perform statistical analyses on the data to develop a more complete picture of PSRO impact on the cost of providing care and utilization of services. Statistical studies might include the following:

- Comparison of overall length of stay pre- and post-PSRO review implementation.
- Determination of the most frequently occurring diagnoses causing admissions to hospitals pre- and post-PSRO implementation.
- Analysis of hospital stays which are less than three days to determine if the number is increasing or decreasing since PSRO review has been initiated.
- Analysis of the cost of inpatient services provided to Title XIX recipients pre- and post-PSRO review implementation.

The most troublesome limitations which State agencies will encounter in trying to perform these analyses will be unavailable or unsuitable pre-PSRO baseline data. Unless data have been collected in the same form for several years prior to PSRO implementation as well as following implementation of PSRO review, it will be difficult for State agency staff to determine if the data elements used in the studies are comparable. For example, if frequency distributions are to be developed for the top twenty principal diagnoses for two years pre- and post-PSRO review implementation, it would have to be determined that the definition of what constitutes a principal diagnosis has not been altered throughout the specified four-year period.

If cost analyses are to be performed to determine if, as a result of PSRO review, State agencies are expending more funds to provide inpatient services to Title XIX recipients, a statistical study would have to build controls to compensate for the following:

- Inflation factors.
- Changes in benefits included in the State plan.
- Changes in benefit restrictions.
- Increases or decreases in eligible population mix and size.
- Other relevant demographic factors.

If adequate controls are not appropriately applied to statistical analyses, the results of the studies will not be valid or useful to those attempting to derive information from them. Another consideration is that these types of studies can be time consuming and, therefore, costly to perform on a regular basis. States must weigh anticipated costs of studies against benefits expected to be derived to determine what types of studies are reasonable and worthwhile to perform as part of their PSRO monitoring effort.

Relevant Issues and Implementing Guidelines

In implementing this approach to monitoring PSRO performance certain issues must be taken into consideration by the State to determine what impact they have on their monitoring plans. State findings should be routinely discussed with PSROs. The discussion presented below will be keyed to the relevant steps of the previously outlined approach.

If a random sample of claims is chosen as a method for monitoring PSRO performance, it is important that the sample be large enough but no more than 20 percent to accurately reflect what is going on in the PSRO area. The purpose of the review is to project the findings from review of a limited sample of claims to all claims which have been reviewed by the PSRO in a given period of time. If the sample size is too small, it will be impossible to make valid projections. Estimations of sample size can be done scientifically through application of statistical techniques, such as the binomial distribution, which would result in different size samples being selected for each review cycle. Another alternative technique is to establish a fixed percentage of claims to be sampled which is uniformly applied during each review cycle. This latter approach may be adequate to meet the needs of most States, especially if, over time, it is demonstrated that the sample drawn does present an accurate picture of the results of PSRO review. The sample size suggested in the example in Exhibit 3-12 is a fixed seven percent random sample of claims received from each PSRO. Such a sampling approach ensures that each PSRO is appropriately represented in the analysis. There are a variety of techniques which can be used to select the sample. Random selection in which the Medicaid number is utilized is one approach. It involves matching the terminal digit of the Medicaid number on the claim with a number selected in a random manner to identify that claim for review. A second method involves selecting a number from 1 to 9 at random and then pulling every tenth or twentieth claim (depending on the interval desired). In the example, a suggested method of selection was not delineated because each State will have to make its own determination concerning its needs. It should be noted, however, that in the example the distribution of claims reviewed among hospitals within the PSRO is not controlled to reflect seven percent of claims, because it was believed that such a guideline would be administratively difficult for State agency staff to follow. The State agency should periodically review the sample size selected for each hospital to

determine if there is proportional representation between the number of claims received from each hospital and the number of claims reviewed. If a distribution problem exists, methods for selecting the sample will have to be adjusted, or a special review of the underrepresented hospitals claims be performed. It would be possible for the State agency to select a percentage sample of claims received from all PSROs within the State. This approach would create additional problems of ensuring proportionate representation of each PSRO, as well as among hospitals within each PSRO.

Reviewing claims for lengths of stay which exceed State specified norms assumes that claims which are forwarded to the State agency are coded for diagnoses. If codes are not required by the State, it will be extremely difficult to determine comparability between a handwritten diagnosis and printed, ICD-9-CM, diagnostic codes. It should be noted that since PSROs certify individual lengths of stay on the basis of medical necessity, length of stay norms utilized by the State and PSROs may not always be in agreement.

Refer claims with lengths of stay which exceed State specified norms to physician staff or other medical specialists qualified to review the PSRO's determination on medical necessity.

Several approaches to reviewing hospital charts can be taken in accomplishing the task. The PSRO should be notified by the State of the records selected for review in all cases. The PSRO could get the records from their hospitals for the State agency to review. Another alternative would be for the hospital to be notified of the impending review and requested to send a copy of the designated medical record to the State agency for review. Finally, a physician or medical specialist employed by the State agency in a consultant capacity could go to the hospital and personally review the record. This latter approach involves logistical problems of travel, ensuring the availability of adequate staff, and complying with State laws on confidentiality.

In determining whether the length of stay indicated on an individual claim is excessive, or the admission was justified, the following items are some of the variables which could be considered.

- The diagnosis code on the claim is compared to the diagnosis indicated in the chart to verify that they coincide.
- Overall quality and completeness of the medical record is noted.

The State agency could review the chart in light of the variables presented above. The decision as to whether a particular length of stay is medically necessary or not will be made through use of implicit and/or explicit criteria,

depending on the individual agency's predetermined ways of conducting reviews. It is expected that these professionals would be instructed to follow the State's guidelines and that the PSROs would be informed of these guidelines.

The variables suggested above provide some guidance to the State in making determinations of whether admissions or lengths of stay were justified. While admittedly professional judgment is a major factor in making determination, it is emphasized that the State's reviewer should be impartial. If the PSRO agrees with the State's determinations there will be no problems. If the PSRO does not agree, the State and PSRO will have to mutually work out their differences. A particularly difficult situation will be when the issue at hand is a matter of quality of care versus dollars expended.

Retrospective Review Staff Requirements

The type of staff required to perform retrospective review include the following:

- Clerical staff to select the random sample and perform the first level review concerning excessive length of stay (applicable to manual system).
- Medically trained analytic staff to perform second level review to verify that the length of stay indicated on the claim exceeds Medicaid norms for the diagnostic category. These staff persons should also be capable of performing simple statistical studies such as, length of stay trend analysis, cost comparison and other studies considered to be important by the State agency.
- Physicians or other highly trained medical staff to review the charts of those patients whose length of stay was declared excessive at the second level review. These persons will discuss these cases with the PSRO, where appropriate.
- Medically trained administrative staff who are able to communicate findings and apparent problems to the PSROs. It is particularly important that these staff persons be capable of communicating with the PSRO's administrative staff, the review coordinator supervisor, and the review coordinators who are working in the field.

Protocol for Fiscal Agent Review

For States which utilize the services of fiscal agents for review and payment of claims submitted by providers of services to Title XIX recipients, a possible random sample monitoring approach could be similar to the one being

initiated by the Bureau of Health Insurance (BHI) with Medicare fiscal intermediaries. BHI's system is based on postpayment review of a 20 percent sample of PSRO cases by the fiscal intermediary. For purposes of illustration, the same percentage sample is applied herein. The reviews of selected cases are conducted monthly, with summaries being compiled quarterly for submission to the State agency. This is an exception based system in that only questioned cases are intended to be reviewed in depth by the State agency and its PSROs.

Fiscal agents will be responsible for initiating and monitoring this exception based system. The system requires a cooperative relationship among the State agency, fiscal agents, and PSROs in order to be a useful monitoring tool. The basic components of this system are as follows:

(1) The fiscal agent selects on a monthly basis a 20 percent sample of paid inpatient service claims. The sample selection process will depend upon procedures agreed upon by the State agency and its fiscal agent. The sample should include a proportional number of claims from each hospital relative to the total number of claims submitted.

(2) Claims will be reviewed by fiscal agent physicians as to whether more or less days would have been paid by the fiscal agent than were certified as being medically necessary by the PSRO.

(3) For claims where more or less days would have been paid by the fiscal agent, these claims are considered to be questioned cases.

(4) A summary report is prepared on the outcome of the review of the 20 percent sample. This report is submitted to the State agency.

(5) A copy of this summary report is submitted to the PSRO and discussed with the PSRO.

(6) A summary of questioned case report will be prepared for each one. These reports may include:

- PSRO name.
- Hospital name and/or number.
- Patient's name*
- Patient's Medicaid number*

---

*Confidential information not to be forwarded elsewhere.

- Dates of admission and discharge (or death).
- Indication as to whether the fiscal agent would have paid more or less.
- Number of days involved.
- Fiscal agent physician's rationale for questioning the case.
- Fiscal agent physician's signature.
- Date of signature.

(7) Summary of questioned cases reports will be prepared by the fiscal agent on a quarterly basis and submitted to the State agency.

(8) Copies of the summary of questioned cases reports will be submitted to the PSRO.

(9) Opportunities to discuss the cases are arranged by the State agency between the fiscal agent and PSRO, upon request. At the State's discretion, the fiscal agent and PSRO can meet to discuss the cases without involving State agency staff.

Exhibit 3-14 presents a sample format as a summary of postpayment review of PSRO cases. In this example each of the PSRO's hospitals is named and its delegated status indicated. The total number of claims received by the fiscal agent from each hospital for the quarter is presented. A proportionate number of claims from each hospital is included in the sample (in this case 20 percent). The number of cases is presented in which the fiscal agent would have paid for more or less days than certified medically necessary by the PSRO. In this example, ancillary service review has not yet been implemented by the PSRO.

Exhibit 3-15 is a suggested format for presenting the summary of each questioned case. It is up to the discretion of the fiscal agent and State agency to develop the format for reporting this information.

Protocol for Automated Claims Review Systems

For States or for fiscal agents acting on behalf of States, with automated claims processing/review systems, all claims from PSROs would be passed through the normal automated edit checks during the payment process. Those that fail the admission/length of stay norms in these screens would still be paid, but would be reviewed initially by clerical staff who would determine if clerical errors caused the claims to fail the screen. If it were unable to be determined from this review whether the claims should have failed the screen, they will be referred to trained review specialists who are, in general, persons knowledgeable in the health

Summary of Postpayment Review of PSRO Cases

Prepared by Fiscal Agent

Quarter Ending: December 31, 1979
Fiscal Agent Name: XYZ Ins. Co. ID #12345
PSRO Name: ADF Medical Care Foundation

Hospital Provider Name (1)	Delegation Status FD/ND/PD (2)	Total # Claims Rec'd. (3)	Sample Size Sel. for Review (4)	Questioned Cases Routine Admissions				Ancillary Service (If Applicable)	
				More		Less		More	Less
				# Cases (5)	# Days (6)	# Cases (7)	# Days (8)	(9)	(10)
ABC Hosp.	ND	2320	463	2	5	3	7	NA	NA
DEF Hosp.	PD	4760	952	3	8	5	12	NA	NA
GHI Hosp.	FD	9850	1970	10	22	6	11	NA	NA
JKL Hosp.	FD	2103	420	1	3	0	0	NA	NA
MNO Hosp.	FD	5670	1134	4	6	2	5	NA	NA
PQR Hosp.	ND	900	180	0	0	1	2	NA	NA
STU Hosp.	PD	1340	268	2	5	1	3	NA	NA
TOTALS		26,943	5389	22	49	18	40	NA	

Prepared by: _____ Date: January 24, 1980

Exhibit 3-14

SUMMARY OF QUESTIONED CASE REPORT

1. PSRO _____ 2. Provider _____

3. Patient's last name* _____

4. Medicaid number* _____

5. Admitted _____ Discharged/Died _____

6. Would the fiscal agent have approved: More _____

Less _____

7. Number of days involved _____

8. Rationale for disagreement:

_____

_____

_____

_____

_____

_____

_____

_____

_____

9. M.D. Signature _____

10. Date _____

*Confidential information not to be forwarded elsewhere.

Exhibit 3-15

care field, (such as nurses) and then, finally, to physician consultants. The State agency would make the determination as to whether the stays were in fact justified and the PSRO would provide input as described in the Complaint System. The States would keep records of the numbers of "unjustified" claims. The ratio of unjustified claims to total claims reviewed would be periodically calculated by the State to determine if this number falls within predetermined guidelines. Each State which utilizes this system must set its own "level of acceptability" with regard to unjustified claims. It is also presumed that the States will receive input from their PSROs concerning these criteria. States and PSROs must work out the details of corrective actions which should be taken if the unjustified claims ratio falls outside of established limits. Reports on this aspect of the system would reflect the outcome of retrospective review of individual claims.

The claims processing system would keep track of average length of stay, and total days of stay per thousand eligibles in the PSRO area. These indicators would periodically be compared against either pre-PSRO baseline data or against other specified norms. Action would be indicated if the PSRO's days of stay or average LOS exceeded the comparison standard by a stipulated percentage for a given time period, say six months. If it were shown for individual claims that the PSRO's days of stay or average LOS had been reduced relative to the comparison standard for a particular diagnostic category, a notation of positive performance would be made. This approach would give the PSRO "credit" for cases in which their criteria were more rigid than the State's screens. The computer programs could be written so that these cases would offset cases in which PSRO authorization exceeded the screens. Reports on this aspect of the system would focus on statistical analysis of the composite review data.

Such a monitoring concept has several advantages which include the following:

- It can be done with little or no increase in cost to the State, since the incremental cost of screening claims is essentially zero.
- It only looks at outcome. The PSRO is free to follow its own review procedures as long as its experience is satisfactory. Only those claims which are causing problems need further attention.
- It is completely objective in terms of both procedures and performance standards. Objectivity is vital in this case, because both the State and the PSRO have previously agreed upon benchmarks against which performance is being compared.

It can be expected that each State will want to tailor this concept to its own particular needs and system (e.g., setting its own norms, action levels,

review criteria, etc.) but in general, the basic approach should be applicable to all States which currently have initiated the Medicaid Management Information System (MMIS) or other automated claims review and processing systems.

The critical components of the automated monitoring system are the retrospective and statistical performance evaluations. While States may differ somewhat on the details of automated review, a general description of how the process might work is as follows:

(1) Review all claims for accuracy, completeness, etc.

(2) Keypunch claims and submit to computer.

(3) Pass all claims through the basic MMIS-type LOS/admission screens, print out the claim number, other review data, and approve the claim for payment. Clerical staff may be used as first level review following computer screen.

(4) On a monthly or more frequent basis, refer all failed claims which have not been otherwise disposed of to trained medical specialists (such as nurses) and then to physician staff for medical review. These staff can be full-time employees, field consultants or other available State personnel.

(5) Obtain copies of the hospital chart and supporting data for rejected claim if the problem cannot be resolved through discussions with the PSRO. These charts will be required for the review process. The PSRO can obtain a copy of the charts, the hospital can make a copy of the charts, or the charts can be reviewed on site by the assigned review physician.

(6) Claims that are judged to contain excessive days of stay or inappropriate admissions are referred to the PSRO for explanation. If an explanation does not arrive within a certain time period, it should be deemed to be an unjustified claim for purposes of State agency records. If the PSRO cannot resolve the disagreement concerning the appropriateness of the admission or length of stay, the claim should also be considered unjustified by the State. However, PSRO determinations on admissions or lengths of stay are final and claims for services included in the State plan which are considered unjustified for purposes of State agency records must be paid.

(7) Periodically, the State should compute the unjustified claim ratio, e.g., the number of days of stay authorized by the PSRO divided by the total state-allowed days of stay over the given time period. If this ratio exceeds some predefined boundary (say five percent) for a given time period (say three months), and if the statistical criteria are not met (see below), then meetings should be held with the PSRO to work out a plan of corrective action.

In addition to this retrospective process, a statistical test of PSRO performance should be developed as follows:

(1) A baseline period for total days of stay comparison could be specified in the State plan for monitoring PSROs. The baseline could include the previous year's total days of stay prior to PSRO review, implementation, a moving average, a nearby non-PSRO comparison area, or other agreed upon bases. The basis for computing total eligibles should also be specified so that changes in the number of eligibles is included in the formula.

(2) On a monthly basis, the information system should compute average LOS and total days of stay per thousand eligibles in the PSRO area, either in total or by major diagnostic class. This result should be divided by the current comparison baseline value. If the result exceeds some previously-specified limit (say five percent) for a set number of months (say three), meetings should be held with the PSRO to work out corrective actions.

While each State will have to work out the details of its own monitoring system, Exhibits 3-16, 3-17, and 3-18 illustrate the process of retrospective and statistical review and may provide some help in structuring specific systems.

Exhibit 3-16 illustrates a quarterly worksheet for statistical review of a given PSRO. This worksheet could be filled out by the claims processor, whether it be the State or fiscal agent. It simply compares average LOS and total days of stay per thousand against the previously established baseline. The diagnosis-specific details provide an indication of where problems exist; the totals provide the basic performance indicator.

Exhibit 3-17 illustrates a quarterly worksheet for retrospective review. This report must be prepared by the State, since State consultants will be doing the review of remanded claims. Again, the tabulation process is straightforward. Column (a) shows the number of each claim that failed the automated screen criteria, and column (b) shows how many days were certified by the PSRO for that

STATISTICAL CLAIMS REVIEW REPORT

Prepared by: State or Fiscal Agent | Date: 4-15-79

Period From: 1-1-79 Through: 3-31-79 | PSRO: XYZ

Indicator Diagnosis	Current Avg. LOS	Performance Days/1000	Baseline Avg. LOS	Comparison Days/1000	% Difference Avg. LOS	% Difference Days/1000
Diabetes	5.4	12	4.2	11	+1.2	+1
MI	11.2	6	10.1	6	+1.1	0
Appendicitis	4.1	8	4.5	7	-0.4	+1
BPH	6.0	3	7.2	3	-1.2	0
T & A	2.5	12	2.4	13	+0.1	-1
TOTAL	5.84	41	5.68	40	-0.16	-1

Exhibit 3-16

RETROSPECTIVE REVIEW REPORT

Prepared by State		**Date** 4-15-79	
Period From 1-1-79	Through 3-31-79	**PSRO**	QRW
Total Certified Days This Quarter	890	12 Months to date	3420
Total Days This Quarter	889	12 Months to date	3424

REVIEWED CLAIMS

Claim No. (a)	Certified Days (b)	State Approved Screens (c)	Days After Review (d)	Difference (e)
29310	5	4	5	0
30312	10	9	9	1
42130	8	4	6	2
42139	15	11	14	1
42190	12	10	10	2
TOTALS	50	38	44	6

Performance: $\frac{\text{Total Certified Days}}{\text{Total Authorized Days*}} = \frac{3420}{3424-6} = 1.00$

*Equals total days - total difference (column e)

Exhibit 3-17

claim. Column (c) shows how many days would have been authorized in accordance with State screens, and column (d) shows days that would actually have been paid by the State after review. Column (e) then shows the difference (certified versus would have been authorized). The basic performance measure is then total certified days divided by the total number of days that would have been authorized if the State had done the review.

Finally, Exhibit 3-18 shows summary performance statistics for each PSRO for both the statistical and retrospective components of monitoring. Both quarterly and yearly data are presented in case the action criteria are a combination of current and long-term performance. This worksheet provides the basic information for the States to use in determining what impact each PSRO has had with regard to service utilization.

Relevant Issues and Guidelines

In implementing this automated review concept, a number of issues will need to be considered and resolved by the State. These include:

(1) Staffing. The system will require the use of clerical staff, trained medical specialists and physicians to review failed claims and to work with the PSROs. Most States who run automated claims systems already have access to such personnel, either working directly for the State (as employees or consultants) or through the fiscal agents. It is not likely that this staff will need to be expanded for the monitoring function; indeed, States with prior authorization systems may find that they can reduce their consultant staff in PSRO areas.

The monitoring system will also require trained analytical staff to collect and analyze performance data. Such staff should usually be available as part of the data processing department (State or fiscal agent), and little or no additional staff should be required.

(2) Data Processing. The claims system will require some modification to pay all PSRO claims (whether screened out or not), produce a special printout of remanded PSRO claims, and compute the ratios of unjustified claims and total days of stay. The reprogramming required for these functions should be minimal.

PERFORMANCE SUMMARY

Prepared by	State	Date	4-15-79
Period From	1-1-79	Through	3-31-79

PSRO Name	Statistical — Current/Baseline				Retrospective — Certified/Authorized	
	Quarter		12 Months to date		Quarter	12 Months to date
	LOS*	DOS*	DOS	LOS		
QRW	1.01	.99	1.05	1.03	1.00	1.03
XYZ	1.03	1.03	1.10	1.13	1.02	1.09

*LOS - Length of Stay

DOS - Days of Stay

Exhibit 3-18

(3) Acceptability of Screens and Review Criteria. To the extent possible, the automated screens should be discussed with the PSROs and accepted by them as reasonable. The procedures used for reviewing remanded claims should be as objective as possible, and should also be discussed with the PSROs prior to implementation. These actions should minimize the possibilities of problems between the State and PSROs on unresolved claims.

4

CONCLUSION

This manual has presented a basic framework with several approaches for States to adapt or use in their efforts to monitor PSRO activities. These approaches have been briefly presented to outline procedures and possible reports which could be utilized in their implementation. While presenting them separately, Bureau of Program Operations and HSQB have noted that individual components of each could be integrated into a different kind of system, particularly tailored to meet the needs of a specific State. The Bureau and HSQB have worked together to develop these alternative approaches to be presented to the States as possible mechanisms for monitoring their PSROs. While it was not possible to integrate the individual characteristics of each State's current claims review mechanisms into these approaches, the Bureau and HSQB anticipate that States will be able to adapt the framework to their own needs.

APPENDIX A

SRS AT 76-140

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

PROGRAM INSTRUCTION

ACTION TRANSMITTAL
SRS-AT-76-140
September 3, 1976

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Title XIX, Social Security Act - Involvement of State Medicaid Agencies in PSRO Implementation

ATTACHMENT: Explanation of (a) the stages of State involvement in PSRO implementation, (b) Federal and State monitoring of PSRO performance, and (c) procedures for States to make complaints about PSRO performance.

RELATED ISSUANCE: This AT supersedes SRS-IM-76-27 (MSA), issued June 22, 1976.

ACTION REQUIRED: Submit State plans for monitoring PSRO performance to the SRS Regional Commissioner prior to their implementation.

INQUIRIES TO: SRS Regional Commissioners

Commissioner
Medical Services Administration

INVOLVEMENT OF STATE MEDICAID AGENCIES IN THE PSRO PROGRAM

To assist the Department in the effective implementation and administration of the PSRO program and to assure the States an active role in those aspects of the program directly impacting on the States, a comprehensive approach to State involvement in the program has been developed. The approach provides for: (1) stages of State involvement in PSRO implementation, (2) Federal and State monitoring roles, and (3) a complaint system through which State concerns regarding the impact of PSRO review determinations on State expenditures or the quality of care given to Medicaid patients may be addressed

INVOLVEMENT OF STATE MEDICAID AGENCIES IN THE PSRO PROGRAM

INTRODUCTION

To assist the Department in the effective implementation and administration of the PSRO program and to assure the States an active role in those aspects of the program directly impacting on the States, a comprehensive approach to State involvement in the program has been developed. The approach provides for: (1) stages of State involvement in PSRO implementation, (2) Federal and State monitoring roles, and (3) a complaint system through which State concerns regarding the impact of PSRO review determinations on State expenditures or the quality of care given to Medicaid patients may be addressed.

With enactment of Public Law 92-603 and the establishment of the PSRO concept, the Congress, the Administration, and the Department made a commitment to the PSRO approach as the way to assure the quality and necessity of institutional health care reimbursed through federal funding. It was anticipated, however, that a long lead time would be required before PSRO could be fully implemented and recognition was given to the necessity of leaving existing Medicare and Medicaid Utilization Control mechanisms in place until an orderly phase-in of PSRO could be accomplished. Furthermore, logic dictates that even after PSRO assumes "binding review", States responsible for administering Medicaid programs would want to be assured that PSROs are effective in carrying out their assigned responsibilities. This can be accomplished by a State-designed system for monitoring PSROs.

The Department and more specifically, the Medical Services Administration, strongly supports State monitoring of PSROs. Although monitoring is not required, we believe that only through a systematized approach to monitoring can a State be assured that PSRO review is effective and that State and Federal dollars for institutional health care are being appropriately spent for necessary and quality care. States should be aware, however, that Federal financial participation for State monitoring of PSRO performance is contingent upon monitoring functions not duplicating the purpose of the PSRO review. More information regarding ways States may be affected by FFP determinations is provided in later sections of this transmittal.

The Department has the responsiblity to continuously monitor the progress and performance of the PSROs and, as indicated earlier, States are not required by the Department to do monitoring. However, as a supplement to Federal monitoring, State monitoring to assure the integrity and effectiveness of PSRO performance can be extremely helpful. As a result of monitoring PSRO performance, the States may identify areas of concern to both themselves and the Department. In subsequent sections of this document procedures are described for States to report problems associated with PSRO review to the Department and for departmental response to State concerns.

STAGES OF STATE INVOLVEMENT IN PSRO IMPLEMENTATION

To assist PSROs in carrying out Medicaid review and assure States a role in implementation of the PSRO program, Department policy provides the following stages for State involvement.

(1) Conditional Designation

PSROs in the planning phase must contact Medicaid State agencies to establish an early State-PSRO relationship during the development of the organization's formal plan for assumption of PSRO functions. Applications for conditional designation containing formal plans and implementation schedules are to be reviewed by State Medicaid agencies. State comments are considered in the Departmental review, and if a State has serious reservations about the organization's review plan or any other matter pertaining to the application, the Department will seek resolution of State concerns prior to making the initial decision on the organization's competency to exercise review and the decision to designate the organization as a conditional PSRO.

(2) Procedures for Correlation of Functions

Each conditional PSRO shall develop administrative procedures for correlating its activities with those of the State prior to beginning review. Departmental policies strongly encourage PSROs to incorporate these administrative procedures in a memorandum of understanding (MOU) to be submitted to the Department for approval prior to the initiation of review. Where a State monitoring plan has been fashioned it may be made a part of the MOU, but in any case, PSROs must consult with the State and work out appropriate procedures, including those pertinent to State monitoring. Assistance in working out these procedures is available from the Department in the event that the PSRO and State are unable to reach agreement.

At the option of the State, administrative procedures may provide that PSRO review be advisory (as opposed to binding) for 60 days after the PSRO begins review in the first hospital so as to allow for administrative adjustments during the initial transition to PSRO review.

(3) Monitoring During the Conditional Period

States are strongly encouraged to monitor PSRO performance by utilizing information provided through existing data collection mechanisms. Upon request by the State, information will be available from routine PSRO reports, regular contacts (including on-site

visits) between the PSRO and HEW project officers, and ongoing appraisal and evaluation activities. States may supplement these mechanisms with additional State data and may conduct case by case monitoring. The Department will implement a system, described below, to assure a prompt Departmental response to State concerns identified at any time during the conditional period.

(4) Conversion from Conditional to Operational Status

At the end of the 24 month conditional period, State recommendations will be considered prior to the decision to convert the PSRO from conditional to operational status. If PSRO performance warrants, the Department has the option to redesignate the PSRO for another conditional period.

(5) Ongoing Monitoring

States are encouraged to continue monitoring even after a PSRO is converted from conditional to operational status. However, monitoring is expected to be less intensive after the conditional period. An intensive evaluation by the Department of a PSRO's capabilities will precede conversion from conditional to operational status. The Department will continue to monitor operational PSROs. States will be encouraged, as in the conditional phase, to participate in site visits conducted by the Department and to utilize the results of departmental monitoring activity in conjunction with their own monitoring.

FEDERAL AND STATE MONITORING ROLES

Routine quarterly and annual reporting by PSROs, special studies, frequent contacts with Departmental staff, including site visits, and the results of appraisal and evaluation activities are all activities associated with Departmental monitoring and assessment of PSRO performance. States will be provided information resulting from Departmental monitoring but, in addition, States may elect to institute their own monitoring activities.

Federal Matching

The Federal government will match State expenditures for a variety of monitoring activities. In essence, the Department will provide FFP in the cost of State monitoring intended to assess the propriety and effectiveness of PSRO review of care provided Medicaid patients. However, as indicated earlier, the Department will deny FFP for similar or identical State functions when those activities duplicate the purposes of PSRO

review or serve to override PSRO decisions as to medical necessity. In addition, if it can be established that a State is not complying with P.L. 92-603, Section 1164, whereby PSRO review is incorporated in the operation of the Medicaid program and PSRO decisions are binding, the Department would then take appropriate action to hold the State out of compliance.

Legitimate State monitoring may be directed, on a sample basis, at assessing individual patient care and/or may be focused retrospectively on profiles of patient care. Since the various activities may include case-by-case patient assessment, evaluation of the PSRO review process, or making statistical comparisons of data, numerous State monitoring functions may, in fact, be similar or even identical to activities routinely performed by PSROs. The question of Federal matching requires a determination that such State activities were valid approaches to monitoring and that the resulting information was used to assess PSRO performance. On the other hand, FFP would be denied if it could be established that information gained from State monitoring was used primarily for the purpose of overriding PSRO decisions or that monitoring procedures reflected PSRO activities so minutely and for such extended periods of time as to belie the assertion that their purpose was exclusively that of assessing a PSRO's performance. In particular, if a State monitoring plan includes a proposal for case by case monitoring, the Department will scrutunize the proposed monitoring activities very carefully to ensure that such monitoring does not duplicate the purpose of PSRO review.

Submittal of Monitoring Plans

To secure appropriate PSRO collaboration and to assure DHEW use of the results of State monitoring, State agencies, prior to implementing their monitoring activities, will submit to SRS for approval a detailed description of their monitoring plans. The plans should be accompanied by comments from (1) those PSRO(s) whose performance will be monitored, and (2) the hospitals impacted by this effort. (Comments from hospital associations representing member hospitals will be acceptable.) If comments from PSRO(s) and hospitals (or their associations) cannot be secured in a timely fashion, the State should indicate that adequate time for review and comment was provided these organizations. The SRS Regional Office should acknowledge receipt of the State monitoring plan within 10 days. If the single State agency has not received acknowledgement within 10 days, it should follow up to assure that the plan has in fact been received.

The SRS Regional Office, after appropriate consultation with staff of PHS should be able to render a decision regarding the adequacy of the plan within 45 days of receipt. If the single State agency has not received a reply within that time period, follow up with the Regional Office should be made.

Problem Referral

In addition to the information accumulated through structured monitoring of the impact of review on the Medicaid program, it is likely that the State will, from time to time, become aware of present or potential PSRO procedural problems. These are problems relevant to the efficiency of PSRO performance, e.g., timeliness of reviews, notices to recipients, etc. These problems should be referred to the SRS Regional Office, which in turn will pass them on to PHS, which has primary responsibility for the review and evaluation of internal PSRO operations.

Monitoring Methods and Data

As the PSRO successfully moves from conditional to "fully operational" status, the State may continue to monitor, at its option, but it is expected that increased State confidence in PSRO performance will result in less expensive, resources-intensive monitoring. During this phase State monitoring is expected to rely more heavily on the review of performance using aggregate statistics, with more intensive methods, such as case-by-case monitoring, reserved for suspected or identified problem areas. Information resulting from Departmental monitoring will also be available to States.

If the State elects to conduct case-by-case monitoring requiring hospital medical records and other information available to the PSRO when making review decisions, the State may obtain these from the PSRO if the State needs are very limited. If the State needs a substantial number of records, arrangements should be made directly with the hospitals. PSRO data and information may be disclosed to the State within the limitations set forth in Departmental confidentiality policy.

In addition to information from the Department and from State monitoring, the State may have historical information appropriate for analyzing differences between PSRO decisions and those made under State review mechanisms. Care must be taken to assure that comparative differences are due to PSRO review and not to extraneous factors such as changes in benefits, eligibility or patient mix.

Summary

States have the option of actively monitoring PSRO review determinations utilizing information available from the Department and from PSROs as well as from State sources. State monitoring should be designed to supplement and complement the monitoring conducted by the Department. Due to the cost involved, intensive State monitoring should be limited to the conditional phase of PSRO development unless a special problem requiring indepth examination is identified.

COMPLAINT SYSTEM

To provide a system for seeking resolution of State concerns identified by the monitoring of PSRO review decisions during the conditional period, five steps have been developed and are suggested to States as the best method for obtaining expeditious review by the Department of their concerns. Initially the State and the PSRO should try to resolve problems identified by the State indicating noncompliance by the PSRO with review procedures required by the Secretary. If the parties are unable to do this the State should report the noncompliance directly to the SRS Regional Commissioner for corrective action.

Formal complaints by States should be based on evidence of a State fiscal problem directly resulting from PSRO review determinations or on indications that PSRO review decisions are adversely affecting the quality of care given to Medicaid patients. Evidence could consist of increased payments clearly due to the PSRO review system, or documentation indicating inappropriate determinations regarding necessity and/or quality of certain care or services rendered to Title XIX patients.

Ordinarily, most concerns will be resolved within steps 1 and 2 of the suggested approach below, as a result of an ongoing working relationship between the State and the PSRO. However, if a conditional PSRO is not responsive to particular State concerns of a serious nature, the State may wish to proceed immediately to step 3.

Step 1. State monitoring should provide ongoing informal feedback to PSROs and the State should bring questionable determinations to the attention of the PSRO for discussion and resolution. This interchange can be especially valuable to PSROs during the early stages of implementing review.

Step 2. There should be formal feedback at periodic intervals on a continuing basis from the State to the PSRO and the Department. Provision for periodic meetings to resolve problems should be a standard element in State/PSRO administrative procedures.

Step 3. Where a State finds that a serious problem appears to exist in the overall appropriateness of PSRO review decisions, the State should seek resolution of the problem by notifying the conditional PSRO and requesting corrective action. The PSRO shall respond to the State request within 30 days. If necessary, a meeting between the PSRO and the State to resolve the matter should be scheduled. At the same time the State notifies the PSRO, the State should also notify the SRS Regional Commissioner of the problem, supported by findings, and then notify him of the results of the meeting.

Since any serious problem is likely to involve disagreements between the State and the PSRO regarding medical necessity and/or quality of care, the parties may seek impartial professional assistance in settling the dispute. Within the 30 day response period, the State and PSRO may, at their option, arrange for a group of knowledgeable physicians, acceptable

to both the PSRO and the State agency, to review the questioned determinations and the bases utilized in making the determinations. The composition of such groups should be previously specified in the PSRO/State administrative procedures. The physician group will advise the parties within the 30-day period of the results of its review, and specifically as to whether, considering the State's assessment, the questioned PSRO determinations were based upon professionally accepted judgments of medical practice. If this advice is accepted by the PSRO and the State, the State should notify the SRS Regional Commissioner of the resolution of the problem.

Step 4. If the activities in Step 3 are unsuccessful and the State regards the problems as having serious impact upon the administration of the State Medicaid program, the State official responsible for the Medicaid program or a higher official of the State, should file a written complaint with the SRS Regional Commissioner accompanied by the PSRO response and the physician group report, if applicable. A copy of the complaint should also be submitted to the Regional Health Administrator and the PSRO. The complaint should: (1) state the problem, (2) specify the State's findings; (3) discuss attempts, if any, at resolving the matter with the PSRO; and (4) based upon the State's judgment as to the seriousness of the problem, request the Department to: (a) work with concerned parties to correct the problem, or (b) temporarily suspend the PSRO's authority to make conclusive determinations.

If the State does not consider the problem serious enough to request suspension of the PSRO's authority to make conclusive determinations, then the Department will formulate a plan and take corrective action within 90 days.

If the State views the problem as serious enough to request such temporary suspension, it is most important that the complaint contain the documentation specified below and copies of communications between the State and PSRO as described in Step 3. The Department will promptly suspend the PSRO's conclusive review authority prior to an extensive, independent Federal assessment if the Department finds that the documentation reasonably supports the State's concern. Any such suspension shall remain in effect until the Department has determined that the PSRO should resume responsibility for review decisions. Immediate suspension of the PSRO's conclusive review authority prior to extensive independent Federal assessment is an emergency action which should not be recommended by the State unless the necessity for such action is demonstrated.

For thorough Departmental consideration, complaints should be accompanied by documentation specifying (1) the alleged improper review determinations of the PSRO, (2) detrimental impact on State Medicaid expenditures and/or the quality of care received by title XIX patients and (3) the correlation between (1) and (2), including indications that factors other than PSRO review which may have contributed to the problem have been examined and eliminated. The Department shall review the complaint

within 30 days of receipt and, if it finds the accompanying documentation reasonable, it will promptly suspend the binding review authority of the PSRO pending a full investigation. The PSRO review system will remain in place and functioning, but PSRO determinations will be advisory to the State during the time of suspension.

It should be noted that the Department has the authority to suspend the PSRO's authority and place the PSRO on advisory status only during the conditional period. Once the PSRO is in fully operational status, termination is the only recourse available to the Department following determination of unsatisfactory performance, pursuant to Section 1152(d) of the Act. The operational PSRO may request and receive a formal hearing prior to such determination.

Step 5. After suspension of the conditional PSRO's conclusive review authority at the request of the State, the Department will conduct an independent assessment of the problem. The Department will utilize a team of expert physicians and others for this purpose which may include, but is not limited to, representatives and designees from the National PSR Council, the Statewide PSR Council if there is one, the State agency, and the Department. If the Department finds that the conditional PSRO is not performing in a satisfactory manner the duties and functions the PSRO was initially found capable of performing upon designation, then the Department may:

(1) place restrictions upon the PSRO's exercise of full review responsibility or the performance of certain duties and functions, including revision of the PSRO's phase-in timetable;

(2) require the PSRO to take corrective action, including the acceptance of technical assistance to improve its performance;

(3) continue the full or partial suspension of the authority of the PSRO to make conclusive determinations for a period of time during which the PSRO's determinations shall be only advisory to the State until the PSRO can demonstrate that corrective measures have been taken; and

(4) terminate the agreement with the PSRO upon 90 days' notice to the PSRO, pursuant to Section 1154(c) of the Act.

APPENDIX B

SRS AT 76-141

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

INTERPRETATION

PLAN PREPRINT

ACTION TRANSMITTAL
SRS-AT-76-141(MSA)
September 3, 1976

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Relationship of PSRO Review Responsibilities to the Medicaid Program - Financial Penalties under Section 1903(g)(1) of the Social Security Act and Federal Financial Participation.

REGULATION REFERENCE: 45 CFR 250.20.

RELATED ISSUANCE: SRS-AT-75-42(MSA), dated June 25, 1975: Relationship of PSRO Review Responsibilities to the Medicaid Program.

ATTACHMENTS:

1. Interpretation of effect on State responsibility and liability and on Federal financial participation.

2. Revised pages 1 and 2 of the Title XIX preprinted State plan. The revision reflects that the provisions of Title XI, Part B of the Social Security Act are applicable to State plans, that States are bound by final PSRO decisions made with respect to Medicaid recipients, and that they are not held responsible under the plan for functions for which final authority has been given to PSROs.

ACTION REQUIRED: Submit the revised preprinted pages to the SRS Regional Commissioner by December 3, 1976.

INQUIRIES TO: SRS Regional Commissioners

W. Kirk Patrick

Commissioner
Medical Services Administration

INTERPRETATION: Impact of PSRO Assumption of Review Responsibility on State Agency Responsibility and Liability; and on Federal Financial Participation

BACKGROUND:

SRS-AT-75-42(MSA) informed all Medicaid single State agencies that, as a result of the Secretary's decisions of February 24, 1975:

1. Conditional PSROs found competent would exercise final authority on issues of medical necessity, quality and appropriateness of care for purposes of claims payment in the Medicaid program;

2. An initial finding of PSRO competency would be made upon conditional designation of the PSRO, and would be subject to reappraisal during the conditional period; and

3. The review systems implemented by conditionally designated PSROs would be accepted by the Department and by Medicaid State agencies as meeting the utilization review requirements imposed by title XIX for those facilities for which the PSRO had assumed review functions. (Section 1164 of the Act makes the PSRO requirements of title XI, Part B, applicable to the operation of State plans involving payment for health care services.)

AT-75-42 also specified that:

1. Although a Memorandum of Understanding (MOU) between the single State agency and the conditional PSRO is not a prerequisite for the assumption of review responsibility by PSROs, it is expected that such parties will enter into such an agreement in good faith in order to facilitate working relationships (the Regional Offices will provide any needed assistance in helping States and PSROs to develop such agreements); and

2. The Secretary's decisions would be implemented by regulations which would provide, in part, for relieving States of responsibility and liability for those utilization review functions for which a PSRO has assumed responsibility.

Because there is some confusion as to whether financial penalties can be imposed under section 1903(g)(1) of the Act in relation to review functions which PSROs have undertaken, and because it may be some time before regulations are published, SRS wishes to make clear to what extent States are relieved of responsibility and liability. Also, the question has arisen about the availability of FFP if a State does not adhere to PSRO medical necessity decisions.

INTERPRETATION:

A. State Relief from Financial Penalties

Specifically, States are relieved from making a satisfactory showing of effective utilization review and from being subject to financial penalty under section 1903(g)(1) for the following functions in those facilities where a PSRO has assumed review responsibility: physician certifications and recertifications (section 1903(g)(1)(A); physician plan of care in short-stay hospitals (section 1903(g)(1)(B); and utilization review (section 1903(g)(1)(C).

The SRS Regional Commissioners will notify States of relief from review responsibility and liability for each facility as binding review authority is assumed by the PSRO .

The Department is currently examining the relationship between PSRO review and the following requirements under section 1903(g)(1): physician plan of care in long-term care institutions, medical review, and independent professional review. States remain responsible for a satisfactory showing with respect to these requirements until instructions are issued which indicate otherwise.

B. Effect on FFP of State Non-adherence to PSRO Medical Necessity Decisions

1. If a State review or monitoring system duplicates the purposes of PSRO review, FFP will not be available for the costs of such State activities.

2. If a PSRO disapproves services as not medically necessary or appropriate and a State nevertheless pays the claim, FFP is not available (except for payment generally authorized by the single State agency for "administrative days"), since section 1158 of the Act prohibits payment of Federal funds where a PSRO has disapproved services. If a PSRO approves services as medically necessary and appropriate and the State denies payment on grounds of lack of medical necessity,

no FFP question arises with respect to the services since the State will not claim any Federal matching. However, in the above instances, a question of substantial compliance with the State plan arises and appropriate HEW action will be taken.

The Department strongly supports the implementation of PSRO review as the mechanism to control unnecessary health care utilization and improve the quality of health care provided Medicaid patients, and we strongly encourage PSROs and State Medicaid agencies to work together closely to help achieve these objectives.

Revision: SRS-AT-76-141 (MSA)
September 3, 1976

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE_____

Citation
45 CFR
Part 201
P.R. 10-9

AT-76-141

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the _____
(single State agency)
_____
submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

45 CFR
205.100
P.R. 10-16

SECTION 1. SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

(a) The _____
_____
is the single State agency designated to administer or supervise the administration of the medical assistance program under title XIX of the Social Security Act. (All references in this plan to "the State agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority whereby it administers or supervises administration of the program.

(b) The State agency which administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965 has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

/ / Yes. The State agency so designated is

_____.
This agency has a separate plan covering

Citation
45 CFR
205.10
P.R. 10-16

AT-76-141

that portion of the State plan under title XIX for which it is responsible.

/ / Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

/ / Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

/ / Not applicable. Waivers are no longer in effect.

/ / Not applicable. No waivers have ever been granted.

(d) / / The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for medical assistance under this plan.

/ / Determinations of eligibility for medical assistance under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the State agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

(e) All other provisions of this plan are administered by the single State agency except for those functions for which final authority has been granted by the Department of HEW to a Professional Standards Review Organization pursuant to title XI of the Act.

(f) All other requirements of 45 CFR 205.100 are met.

APPENDIX C

MSA AT 77-43

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D. C. 20201

PROGRAM INSTRUCTION

ACTION TRANSMITTAL
AT-77- 43 (MSA)
April 15, 1977

TO:	STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS
SUBJECT:	Title XIX Social Security Act - Elements for Assessment of State Plans for Monitoring Conditional PSROs
ATTACHMENT:	Explanation of the items which will be used to assess the acceptability of a single State agency plan to monitor the performance of conditional PSROs.
RELATED ISSUANCE:	SRS-AT-76-140, September 3, 1976
ACTION REQUIRED:	States must observe these elements in preparing monitoring plans.
INQUIRIES TO:	Regional Commissioners

for Commissioner
Medical Services Administration

Elements for Assessment of State Plans for Monitoring Conditional PSROs

A. The sSa must provide a detailed description of monitoring techniques to be used. Any one or a combination of the three general types of PSRO monitoring will be accepted, as well as other techniques provided the conditions stated in paragraph A. 4 below are met.

1. Concurrent Review

-State must not totally duplicate concurrent review process of PSRO. The cases selected by the State should be only those in which the PSRO has made a review decision. The State may only re-review cases in the hospital during the conditional phase on a 100% basis for a very limited period of time; or it may conduct such review on a sample basis not to exceed 20%. After the PSRO has been designated fully qualified, this type of monitoring should be discontinued unless a serious problem is detected through retrospective monitoring.

-State may make on-site visits to hospitals to view the concurrent review process.

2. Retrospective review on a case-by-case basis

-State may review a sample of cases retrospectively, using utilization review techniques in place prior to PSRO implementation and compare these results with PSRO decisions. To control duplicative expenditures, this comparative review should be limited to about a 20% or smaller sample and should not continue beyond one year (or the end of the PSROs conditional phase) unless an analysis of the results indicates a need for continued retrospective review.

3. Trend Analysis

-States may compare summary statistics on the patterns of practice of physicians and institutions, on utilization (such as LOS and admission rates) or on review determinations. These statistics may be analyzed in relationship to impact on State expenditures.

-States may compare summary statistics acquired prior to PSRO implementation with statistics available after PSRO implementation or States may use these statistics to observe the performance of a PSRO over time.

4. In addition to the three types of monitoring listed above States may use other monitoring techniques as long as they do not totally duplicate the PSRO concurrent review process or the other responsibilities which the PSRO has.

B. Other factors important to a sSa design for monitoring PSROs are enumerated below.

1. State monitoring techniques should not be designed to duplicate the decisions made by individual PSRO review personnel. It is the responsibility of the PSRO to supervise or monitor individual PSRO personnel. The State's concern should be that the review decisions do not negatively impact on expenditures or quality of care given to title XIX patients.

2. The plan should identify the types and sources of information to be used in monitoring. Procedures for acquiring data from other than State sources should be included.

3. The plan should contain specific analysis techniques. Report formats, ranges of acceptability and similar analysis tools should be included.

4. Comments from hospitals and PSROs must be included with the plan. Documentation of a request for comment with at least a 30-day comment period and a statement from the State that no comments were forthcoming, are acceptable in lieu of comments.

5. The plan should not duplicate the monitoring process which the Bureau of Quality Assurance will use to evaluate PSROs.

   A. The State may request copies of the PMIS reports sent by PSROs to BQA and thereby use the same information.

   B. The State may accompany Federal personnel on assessment site visits.

6. In accordance with the provisions of AT-76-140, the plan should recognize that all problems identified are to be discussed with the PSRO and resolution sought prior to reporting to the SRS Regional Office or filing a complaint.

7. The plan should contain an estimate of the resources required to carry it out, including monitoring and analysis personnel and other necessary direct costs.

APPENDIX D

BQA General Memorandum 15-77

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
BUREAU OF QUALITY ASSURANCE

TO : Planning and Conditional PSROs and Support Center Organizations; Statewide Councils; PHS Regional PSRC Project Officers

DATE: MAY 13 1977

GENERAL MEMORANDUM NO. 15-77

FROM : Director

SUBJECT: DHEW Involvement in the Evaluation of Single State Agency (sSa) Plans to Monitor PSROs

The purpose of this General Memorandum is to describe the role of the Department of Health, Education and Welfare (DHEW) in the review and approval of single State agency plans to monitor PSROs. The plans are to be submitted to the Regional Commissioner of the Social and Rehabilitation Service (SRS) for approval. Prior to submittal, Professional Standards Review Organizations (PSROs) and hospitals will have an opportunity to comment on the plan. PSROs and hospitals should provide comments in a timely fashion and should, at a minimum, indicate any administrative problem anticipated if the plan is implemented. These comments will be forwarded with the plan.

Although the SRS Regional Commissioner has the ultimate responsibility for plan approval, other components of DHEW will be actively involved in plan review. Comments from the other components will assist the Regional Commissioner in making a decision on the acceptability of the plan.

The SRS-Action Transmittal-76-140 allots a 45-day period for plan review and response. The following procedures have been developed to assure a thorough plan review during this time period. Guidelines to be used in evaluating the plan are appended to this General Memorandum.

In accordance with the SRS-AT-76-140 issued on September 3, 1976, State monitoring plans should be submitted initially to the SRS Regional Commissioner. Comments from affected PSROs and hospitals (or hospital associations representing member hospitals) should accompany each monitoring plan submitted. After the Medical Services Administration (MSA) component of the SRS Regional Office (SRS/RO) receives a State monitoring plan, the steps listed below should be followed in order to ensure that the Division of Quality Standards Regional Office (DQS/RO) and Bureau of Quality Assurance Central Office (BQA/CO) each have an opportunity to review all pertinent materials. The SRS/RO will forward the plan to appropriate Central Office components of the Medicaid Program.

Once the SRS/RO receives the sSa monitoring plan and forwards copies of the plan and related comments to DQS/RO, DQS/RO should:

(A) Immediately forward three copies of the plan and comments to the appropriate desk officer, BQA, Division of Program Operations, Rockville, Maryland 20857; and

(B) Review each plan against the appropriate guidelines and other information available concerning PSRO and sSa activities in the specific State.

In order to coordinate the review of the State plan, DQS/RO should forward its comments (indicating areas where the plan requires revisions and what the recommended changes should be) by telephone or telex (and later in writing) to BQA no later than 10 working days after receiving the plan from SRS/RO. BQA will review the monitoring plan, discuss problems with DQS/RO, and in conjunction with Regional Office comments, formally indicate its acceptance or nonacceptance of the plan to DQS/RO within 10 working days of BQA receipt of the plan. DQS/RO should then immediately prepare a memorandum for the Regional Health Administrator (RHA)[1] formally indicating approval or disapproval of the plan to be forwarded to the SRS Regional Commissioner.

If BQA and DQS find the State plan acceptable, the RHA should notify the Regional Commissioner of the acceptability of the plan. BQA/CO will forward any comments on the plan to MSA/CO.

However, if BQA and DQS find the plan unacceptable, the RHA should so indicate in writing to the Regional Commissioner. BQA/CO will be responsible for forwarding comments and recommendations for modifications to MSA/CO. MSA/CO will contact the SRS/RO to express concern about the acceptability of the plan and work with BQA to develop joint recommendations for revisions which will make the plan acceptable. These recommendations will be forwarded by MSA/CO to the SRS/RO. During the period of issue resolution, the SRS/RO will notify the sSa that the plan is under review and recommendations for changes will be forwarded shortly. The SRS Action Transmittal 76-140 requires that the sSa be notified of the status of its monitoring plan no later than 45 days after SRS/RO receives the plan.

1/ Subject to change as DHEW reorganization is implemented

To summarize the process:

(1) If the SRS Regional Commissioner, in conjunction with comments received from MSA/CO, agrees with the BQA finding of unacceptability, the sSa will be notified by the Regional Commissioner that the plan is not acceptable, and must be resubmitted prior to implementation of the State's monitoring of PSROs.

(2) On the other hand, if the SRS Regional Commissioner disagrees with the PHS decisions concerning the State monitoring plan, then the final decision to approve the plan will be made by MSA/CO after consultation with BQA/CO.

DQS/RO should establish and maintain a working relationship with the staff in the Office of the Regional Commissioner. This will facilitate review of the plan and issue resolution at the Regional Office in the time frame allotted (i.e., within the 45-day limit). If a State monitoring plan has been disapproved and must be resubmitted, DQS/RO should request that SRS/RO provide a copy of the resubmitted plan to DQS/RO. DQS/RO should examine the plan to ensure that the recommended revisions are included. If DQS/RO requires assistance in resolving problems with the modified plan, it should contact BQA/CO immediately. The procedures for approving the revised monitoring plan should be followed in the manner described above. Following final approval or disapproval of the plan, DQS/RO will notify PSROs in their area of the MSA/SRS decision.

Finally, the procedures and principal components involved in the review of State plans to monitor PSROs are subject to change as the Health Care Financing Administration becomes fully operational. However, because of the interest in State monitoring of PSRO performance and the fact that both Medicaid State agencies and SRS Regional Commissioners have already been notified of the procedures and guidelines, the Bureau of Quality Assurance is also making available the same information. You will be notified of any changes in the procedures and criteria should they be modified.

Michael J. Goran, M.D.

Attachment

APPENDIX

Guidelines for the Assessment of State Monitoring Plans

A. Monitoring Procedures

Monitoring plans should not go beyond the scope of State monitoring as outlined in SRS-76-140 and must not duplicate Federal monitoring processes. The State may request copies of the PMIS reports sent to BQA. Aspects of a plan applicable to the management of the Medicaid program are inappropriate for inclusion in a plan to monitor PSRO performance. In addition, State monitoring should not be involved in routinely assessing the PSRO review process or PSRO administrative/management practices. Should the State become aware of problems with the review process or the PSRO management practices, the State should refer these problems to the SRS Regional Office for further discussion with the PHS staff. The monitoring techniques listed below may be employed by single State agencies:

1. On-site monitoring

   a. As stated in the SRS-AT-76-140, on-site monitoring of PSRO review should be limited to activities which do not duplicate the intent and purpose of the PSRO concurrent review process. In addition, on-site monitoring should not parallel the PSRO review process by extending beyond a trial period (usually one year) during which time the State is carefully assessing PSRO determinations. The plan should specify the types of on-site review, the data to be collected, how comparisons will be made with PSRO determinations, the time frame and frequency of on-site monitoring.

   b. States may conduct review of PSRO determinations in the hospital, so long as such review is performed after the PSRO has made its final review determination.

   c. States may conduct review in the hospital following PSRO review on 100 percent of the cases for a limited period of time; or States may perform, for more extensive periods of time during the PSRO conditional phase, such review on a sample basis not to exceed 20 percent. After the PSRO has been designated fully qualified this type of monitoring should be discontinued unless a serious problem is detected through retrospective review or data analysis. States may continue to make on-site visits to hospitals to observe the PSRO concurrent review process but not to re- view cases on a concurrent basis.

2. Retrospective Review on a Case-by-Case Basis

States may review a defined sample of cases retrospectively, using utilization review techniques in place prior to PSRO implementation and compare these results with PSRO decisions. To control duplica-

tive expenditures, this comparative review should be limited to a 20 percent or smaller sample and should not continue beyond one year (or the end of the PSROs conditional phase) unless an analysis of the results indicates a need for continued retrospective review. This type of retrospective review is similar to fiscal intermediary monitoring. The need for continued retrospective review should be documented and approved via the same procedures in which the original State monitoring plan is approved.

3. Trend Analysis

a. States may compare statistics on the patterns of practice of physicians and institutions, as well as on utilization parameters (such as LOS and admission rates), or on review determinations using data from the UHDDS and the certification information provided by the PSRO. The plan should indicate how these statistics will be analyzed in relationship to impact on State expenditures.

b. States may compare statistics acquired prior to PSRO implementation with statistics available from the State after PSRO implementation or States may use these statistics to observe the performance of a PSRO over time. Any protocol developed by the State to compare differences in utilization rates or Medicaid expenditures before and after PSRO implementation must show evidence that potential confounding variables such as changes in benefits, eligibility criteria, patient mix etc., are adequately controlled.

4. Alternate Monitoring Techniques

In addition to the three types of monitoring listed above, States may use other monitoring techniques as long as they do not duplicate the PSRO concurrent review process or other responsibilities of the PSRO such as MCE studies. The State should request action through the Regional Commissioner if they detect problems with the concurrent review process or problems appropriate for MCE studies.

B. Requests for PSRO Data

State requests for PSRO data should be:

(1) designed for monitoring PSRO review determinations and not for tracking or evaluating decisions made by individual review personnel. It is the responsibility of the PSRO to supervise or monitor individual PSRO personnel. These data include the UHDDS and information for certification;

(2) in accordance with BQA confidentiality policies; and

(3) limited to data the PSRO is collecting for review purposes; any requests for data which the PSRO is not collecting may be furnished to the State if the State wishes to contract with the PSRO to collect and provide such data.

If the State has a need for additional data or special reports on an ad hoc basis, the monitoring plan should state that such requests be referred to BQA when the PSRO is unable to furnish them or the PSRO questions the appropriateness of providing the data. Examples of routinely requested report formats should be included in the plan.

C. Additional Plan Elements

(1) The plan should identify the types and sources of information to be used in monitoring. Procedures for acquiring data from sources other than from the State sources should be included. The State may request copies of the PMIS reports and use the information for State monitoring. In addition, the State may accompany Federal personnel on site visits.

(2) The plan should contain specific analysis techniques. Ranges of acceptability and similar analysis tools should be included.

(3) The plan should describe (a) how the difference between the State and the PSRO determinations will be jointly reviewed in order to verify if, in fact, real differences exist, and (b) how the State will identify aspects of the PSRO Program that negatively impact on the quality of care rendered to Medicaid patients and on State expenditures.

(4) In accordance with the provisions of AT-76-140, the plan should recognize that all problems identified are to be discussed with the PSRO and resolution sought prior to reporting to the SRS Regional Office or filing a complaint.

(5) The plan should contain an estimate of the resources required to carry it out, including monitoring and analysis personnel and other necessary direct costs.

APPENDIX E

HCFA AT-78-61 (MMB)

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D. C. 20201

PROGRAM INSTRUCTION

ACTION TRANSMITTAL
HCFA-AT-78-61 (MMB)
July 10, 1978

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Relationships with PSROs; Implementation of Section 5 (d) of P.L. 95-142

RELATED ISSUANCES: SRS-AT-76-140, September 3, 1976
SRS-AT-77-43, April 15, 1977
HCFA-AT-78-5(MMB), January 19, 1978

ACTION REQUIRED: Conformity with statutory requirements of P.L. 95-142 regarding State/PSRO relationships

INQUIRIES TO: Regional Medicaid Directors

EFFECTIVE DATE: On issuance

For Director
Medicaid Bureau

I. Introduction

P.L. 95-142, the Medicare-Medicaid Anti-fraud and Abuse Amendments which in part amended Title XI, Part B of the Social Security Act, contains several provisions relating to the relationships between State Medicaid agencies and PSROs. This transmittal provides an overview of those provisions and gives information to assist in implementation. Previous communications SRS-AT-76-140, SRS-AT-77-43, BQA General Memorandum No. 5-76, and BQA General Memorandum 15-77 which have served as guidance for State agency/PSRO relationships will be updated and modified as necessary to reflect the amendments.

Underlying these procedures is a recognition that States have legitimate interests and concerns regarding PSRO activities and the expectation that States will participate more fully in the PSRO program. In this new legislation,Congress clarified that PSRO review decisions are conclusive; but at the same time, it provided specific responsibilities for States in PSRO development and evaluation. The amendments delineate the conditions under which the review decisions of PSROs are deemed final for purposes of payment.

The procedures outlined here should be viewed in the context of developing effective working relationships. The provisions of this new law provide a set of procedures which, if implemented by all parties in a spirit of cooperation, can help to prevent and, when necessary, solve problems.

The Department is committed to implementing both the letter and the spirit of P.L. 95-142 and will make every effort to assist State agencies and PSROs in utilizing its procedures to foster effective relationships. The cooperation of both State agencies and PSROs will be necessary for the intent of the legislation to be realized.

II. PSRO Consultation with State Medicaid Agencies and Review by Governors

A. State Agency Involvement in PSRO Development

Section 1152(h) of the Social Security Act requires that a PSRO consult with the State Medicaid agency during the development and preparation of (1) its formal review plan (required as a condition for designation), and (2) its plan for review in long-term care facilities, and (3) its plan for review of ambulatory services. PSROs have been urged to begin this consultation at the earliest possible point in the development of each of these plans and to include not only review of drafts but also frequent discussions with State agency staff of plan substance. The intent is for the PSRO and the State

agency to have sufficient interaction regarding each of these plans so that issues will be identified early in the process and resolved and a mutually acceptable approach will be developed. The steps outlined below are intended to assist in achieving this level of interaction:

(1) State agency staff and PSRO staff meet at the beginning of plan development to discuss and agree upon overall goals, plan objectives, general approaches to be used, and a timetable for plan development.

(2) PSRO develops a draft, provides State agency with a copy and meets with State agency staff to discuss it after the State agency has studied the plan.

(3) PSRO rewrites a draft, sends it to the State agency, and the two staffs meet again as often as necessary to resolve issues and finalize the plan.

(4) PSRO prepares the final draft, sends it to the State agency and the State agency staff prepares a letter commenting on the plan from the head of the single State agency to accompany plan submission by the PSRO.

(5) PSRO sends the plan with the letter from the head of the single State agency to its Project Officer and to the Governor as described in the next section.

In the event that assistance is needed in arranging meetings, in resolving issues, or in clarifying the Federal statute or DHEW policy, the State agencies should contact their respective Regional Medicaid Directors.

In States where planning PSROs have already begun the process of developing formal plans or where conditional PSROs have already started long-term care review and/or ambulatory care review plans, cooperative efforts in progress should continue or the consultation process should be immediately initiated.

In States where PSROs have already achieved conditional status, State agency-PSRO consultation should continue as formal plans are modified over time. Interaction with PSROs is a continuing process as Memoranda of Understanding are developed, as monitoring plans are developed and implemented, and as additional review goals or methods are proposed. Proposals by a conditional PSRO for agreement renewal will be describing these areas of State agency involvement and State agencies are requested to provide to the PSRO, on request, a letter from the head of the

single State agency to accompany the proposals. The letter should indicate the agency's support and/or concerns about the proposed activities for the coming year. These comments from the State agency will be used by HCFA staff to assist the PSRO and the State agency in resolving any problems.

At the point of anticipated conversion by a PSRO to fully designated status, recommendations from the State agency and from the Governor as described below will be considered prior to a Department decision.

B. Governor's Review of PSRO Plans

Section 1152(h) of the Act also requires that the Governors have an opportunity to comment on plans (i.e., formal review plans including plans to review long-term care and ambulatory care). Governors must also be asked for comment regarding the conversion of a conditional PSRO to fully designated status. A comment period of 30 days is provided to the Governor. The Secretary is required to consider any comments from the Governor before making a conditional or full designation or making a finding that the PSRO is qualified to perform long-term care or ambulatory care review. If the Secretary intends to make a decision that is adverse to the Governor's comments, he must first provide the Governor with another 30 days in which to submit additional comments. To assure compliance with these statutory requirements the following procedures will apply:

(1) When the PSRO submits its plan (formal review plan, long-term care review plan, ambulatory care review plan, or plan to convert to fully designated status) to its Project Officer for final approval, the PSRO also sends it to the Governor.

(2) A cover letter will accompany the plan from the PSRO stating what the plan is, referencing P.L. 95-142, summarizing the involvement of the State Medicaid agency in plan development, and requesting that any comments be sent within 30 days of receipt of the plan to the HCFA Regional Administrator. A copy of the letter from the head of the single State agency (referred to above) will be included.

(3) If after considering the Governor's comments, the Department intends to take action which is contrary to the Governor's views, the Governor will be informed in writing by the HCFA Regional Administrator and offered the opportunity of submitting additional comments within 30 days of receipt of the letter.

If effective consultation between the State agency and the PSRO has taken place, hopefully the third step will not be required. However, in the event that it is necessary, every effort will be made by the Medicaid Bureau and Health Standards and Quality Bureau to resolve the differences between the State (as reflected by the Governor) and the PSRO. Action to designate a conditional PSRO, convert a conditional PSRO to fully designated status, or approve a long-term care or ambulatory care review plan will not occur until all of the above processes, or a similar process fulfilling the statutory requirement, have been completed.

III. Memoranda of Understanding

A. MOUs Required

The previously mentioned statements of policy (SRS-AT-76-140 and BQA General Memorandum No. 5-76) strongly encouraged a Memorandum of Understanding (MOU). Section 1171(a) of the Social Security Act now requires that the PSRO enter into a MOU with the single State agency, unless a waiver is granted to the PSRO by the Secretary. Determinations made by the PSRO are not conclusive unless such an MOU has been signed by both the PSRO and the State agency and has been approved by the Project Officer or a waiver has been granted by the Secretary. According to the statute the MOU must (1) delineate the relationship between the two organizations; (2) provide for the exchange of data and information; (3) specify administrative procedures and coordination mechanisms; and (4) require modification when additional PSRO responsibility for review is authorized. In States with multiple PSROs, the development of a uniform MOU between the PSROs and the State agency is strongly encouraged.

If the State agency and the respective PSRO(s) do not have a current MOU,it is suggested that the State agency indicate to its Regional Medicaid Director what its intentions are regarding initiation or renewal of an MOU so that a mutually acceptable basis for PSRO review may be established.

If the State does not wish to sign an MOU, it will be necessary for administrative procedures to be agreed upon between the PSRO and the State agency. It is possible for the Secretary to grant a waiver of the MOU requirement to the PSRO. However, agreed upon procedures are necessary so that the PSRO review of services under Section 1158 can be accomplished. The final regulation "Assumption of Review Responsibility by Conditional PSROs" (42 CFR Part 463, Subpart A) describes these procedures.

In accordance with the intent of P.L. 95-142, an approved MOU is to be considered the mechanism for the ongoing relationship between the PSRO and the State Medicaid agency. It is to be a continuing agreement which may be modified at any time upon the agreement of both parties and approval of the Secretary. In the event the State prefers mechanisms other than an MOU, the Health Standards and Quality Bureau Regional Office and the PSRO should be given 60 days notice of such intentions. This advance notice will provide DHEW the necessary time to consider a waiver of the MOU for the PSRO and to arrange for substitute appropriate administrative procedures between the PSRO and the State.

B. If the State agency desires an MOU but cannot reach agreement with the PSRO, the State agency should inform the Regional Medicaid Director and assistance in resolving the matters in dispute will be provided. In the event that a State agency does not wish to enter into an MOU with a PSRO, it should notify the Regional Medicaid Director in writing.

C. Other Goals or Methods

Section 1171(b)(1) of the Social Security Act allows State agencies to request the PSRO to include in the MOU specific goals or methods that are not explicitly already a part of the PSRO's formal plan. During the development and negotiation of the MOU, these additions may be proposed by the State agency. For those PSROs already reviewing Medicaid services under an MOU and according to a formal plan, these additions may be requested by a State agency so that the MOUs and formal plans will be modified to reflect the changes. Review goals should be interpreted to mean specific intended results of the review process. An example is a request from the State agency that PSRO review be modified to achieve a reduction in length of stay for a particular diagnosis or procedure which has been identified and agreed to as a problem by both parties. Review methods should be interpreted to mean specific review activities or mechanisms. An example is a request from the State agency to identify hospitals with high week-end admission rates and institute corrective measures.

In the event that a PSRO and a State agency cannot reach agreement on such proposals from a State agency, the State agency should notify the Regional Medicaid Director and the PSRO should notify its Project Officer. The requested addition will be reviewed and a determination will be made by the

Secretary whether it should be included in the MOU. The statute requires that such an addition be included if it (1) is consistent whth the functions of a PSRO under Title XI; (2) is consistent with the provisions of Title XIX and the State's plan approved under Title XIX, and (3) does not seriously impact on the effectiveness and uniformity of the PSRO review of Medicare and Medicaid services.

D. State Agency - PSRO Contracts

Under Section 1171(c) of the Social Security Act, State agencies may contract with PSROs for the performance of additional review responsibilities beyond those required under the PSRO statute. In such instances, the activity would be considered a Title XIX responsibility and the State agency would be accountable under Title XIX requirements. The statute requires that in order for a State agency to enter into such a contract, it must formally request the PSRO to assume such additional responsibilities. It must also amend its State plan; the responsibilities must not be inconsistent with Title XI, Part B; and the Secretary must approve the State plan. The cost of any such contract is subject to matching by the Federal Government as an expense of the State agency under Section 1903(a) of Title XIX.

IV. State Agency Monitoring of PSRO

As discussed in AT-76-140 and BQA General Memorandum 5-76, the involvement of the State Medicaid Agency in the PSRO program is to assist the Department in the effective implementation and administration of the program and to assure the States an active role in those aspects of the program directly affecting them. As a part of this involvement, monitoring of the PSROs by the State agencies is strongly encouraged.

Section 1171(d) of the Social Security Act now includes provisions for State agency monitoring of PSROs. It includes a process by which the Secretary is required to act on State documentation of PSRO poor performance. In the paragraphs that follow, the monitoring provisions of the new legislation will be sumarized. Other documents on monitoring (i.e., SRS-AT-76-140 and BQA General Memorandum No. 5-76, SRS-AT-77-43 and the Manual for State Medicaid Agency Monitoring of PSROs) provide more detailed information on monitoring policies and procedures.

A. Monitoring Plan

Under Section 1171(d)(1) of the Social Security Act, each State agency has the option to monitor PSRO performance of review responsibilities providing it has developed a State monitoring plan that has been approved by the Secretary.

During the development of the monitoring plan, the State agency is expected to provide the PSROs an opportunity for review and comment. The costs of such approved monitoring activities are reimbursable by the Federal Government as an expense of the State agency under section 1903(a) of the Act. A monitoring plan may include performance criteria to be used in judging the effectiveness of PSRO review. PSROs should be consulted about the criteria and efforts needed to be made by both PSROs and State agencies to reach agreement. In the event agreement about performance criteria cannot be reached, State agencies should notify their Regional Medicaid Director and HCFA staff will assist the State agency and the PSRO(s) in resolving the issues in dispute prior to the plan's approval.

B. Monitoring Results

Section 5(d) of P.L. 95-142 also provides a process by which monitoring results based on an approved plan can be used by State agencies as a means to document suspected poor performance by a PSRO and to support a request for a suspension by the Secretary of PSRO binding review.

The "complaint system" described in SRS-AT-76-140 and BQA General Memorandum No. 5-76 provides detailed instructions for seeking resolutions of State concerns and suspension procedures. Section 1171(d)(3) now provides, by statute, for the final steps of that process. Under the provisions of the statute, if a State agency that has an approved monitoring plan submits reasonable documentation that PSRO review determinations have caused an unreasonable and detrimental impact on both total State expenditures and the appropriateness of care received by individuals covered under the State's Medicaid program, the Secretary is required to take certain actions. Such documentation and a request for Secretarial action should be submitted in writing to the Regional Medicaid Director. The Secretary then must make a determination as to the reasonableness of the allegation within 30 days of the receipt of the documentation. If the determination is made that the PSRO has caused unreasonable and detrimental impact, the Secretary is required to suspend immediately the PSRO's authority, in whole or in part, to make conclusive determinations unless the PSRO has already taken appropriate corrective action. If a PSRO's authority is suspended, the PSRO review system stays in place but the State agency will be able to overturn PSRO decisions. The suspension must continue until a reevaluation reveals that the allegation is not correct or the PSRO has taken corrective action. The Secretary will notify the State agency of his actions and also the appropriate committees of the Congress.

V. Exchange of Data and Information

Reflecting the intent of Congress to ensure that impediments to effective State/PSRO relationships are minimized, Section 1171(e)(2) of the Social Security Act also addresses the issue of what data and information the PSRO can share with the State agency. Essentially, this new provision makes the exchange of data or information with the State agency an exception to the general rule under section 1166(a) of the Act, i.e., that PSROs are prohibited from disclosing data for other than Title XI purposes except as authorized in regulations. PSROs are authorized to provide to the State agency, upon request, that data or information which they are required to submit routinely to DHEW. Additionally, the new statute requires PSROs also to provide State agencies, upon their request, other data or information authorized by the Secretary. PSRO Transmittal No. 67 "Disclosure of PSRO Data and Information to State Medicaid Agencies" has been issued in final form to provide this authorization.

VI. Summary

The requirements of Section 5(d) of P.L. 95-142 provide for frequent interaction between State governments and PSROs at several points in PSRO development and operation: (1) during the development and review of formal plans; (2) during the negotiation of the MOU and the subsequent administration of the review process; (3) during the monitoring process; (4) during the development of plans to expand review into long-term care and ambulatory care; and (5) during the process to convert the PSRO to fully designated status. In order for these requirements to accomplish what the Congress intended, (i.e., smooth working relationships between States and PSROs), they must be carried out by all parties with a spirit of cooperation and a sense of their purpose. The Department is developing relationships and mechanisms at the national level to facilitate this process and will assist individual States and PSROs as necessary. Section 5(d) of P.L. 95-142 provides an opportunity to build effective relationships with PSROs and serious attention to its requirements by both States and PSROs is needed.

APPENDIX F

Selected Detailed Diagnosis Related Groups

Selected Detailed Diagnosis Related Groups

(Series 2)

Detailed Diagnosis Related Group (1)	AUTOGRP* DRG Code (2)	Trim** Point (3)
1. Diabetes of age >35 without operation, without secondary diagnoses or with minor secondary diagnoses	74	27
2. Neuroses (obsessive-compulsive-depressive), personality disorders	92	62
3. Diseases of the eye with extraction of lens, sclerotomy, sclerectomy	110	13
4. Acute myocardial infarction	121	45
5. Ischemic heart disease, without operation, without secondary diagnoses	122	24
6. Cerebral thrombo-embolism without operation, without secondary diagnoses or with minor secondary diagnoses	141	33
7. Hypertrophy of T & A	159	5
8. Acute upper respiratory infection and influenza of age >44	161	25
9. Pneumonia of age < 31 without operation	165	19
10. Pneumonia of age >30 without secondary diagnoses and without operation	166	25
11. Gastric and peptic ulcer without operation and without secondary diagnoses	183	21

Detailed Diagnosis Related Group (1)	AUTOGRP* DRG Code (2)	Trim** Point (3)
12. Hernia of abdominal cavity of age >64 with minor repair operation	204	20
13. Disease of gall bladder and bile duct with operation and without secondary diagnoses	227	24
14. Disease of prostate with trans-urethral prostatectomy and without secondary diagnoses	254	25
15. Disease of female genital organs with hysterectomy, repair, or other major operation	266	21
16. Normal delivery without operation or with minor operation assisting delivery	278	7
17. Arthritis with repair and plastic operation (joint, hip), laminectomy	294	53
18. Fracture of femur, pelvis, multiple without operation	340	60

---

* This code number is provided as a reference to PSROs who have the AUTOGRP system available to them. See Appendix 4 for detailed list of included codes.

** Live discharges, in the indicated principal diagnosis group, whose lengths of stay exceed this value are defined as long stays. See Appendix 5 for further explanation.

APPENDIX G

Selected Procedures with Diagnosis Related Groups

Selected Procedures with Diagnosis Related Groups (Series 3)

Name of Procedure (1)	--Procedure Codes- ICDA-8 (2)	H-ICDA-2 (3)	AUTOGRP* DRG Code (4)	Trim** Point (5)
1 - Cholecystectomy	43.5	51.1		
Disease of gall bladder and bile duct without secondary diagnoses			227	24
Disease of gall bladder and bile duct with secondary diagnoses, age <65			228	31
Disease of gall bladder and bile duct with secondary diagnoses, age >64			229	45
2 - Hemorrhoidectomy	51.3	49.3		
Hemorrhoids			158	18
3 - Inguinofemoral Herniorrhaphy	38.2-38.5	53.0-53.3		
Hernia of abdominal cavity, age <15			197	8
Inguinal hernia (without obstruction) of 14 < age <65 without secondary dx			198	11
Hernia of abdominal cavity, age >64			204	20
4 - Hysterectomy	69.1-69.5	68.2-68.6		
Cancer of uterus - corpus with abdominal hysterectomy			29	29
Cancer of uterus - cervix, ovary with abdominal hysterectomy			30	56
Benign neoplasm of uterus (fibroma), ovary			59	22
Disease of female genital organs			266	21
5 - Transurethral Prostatectomy	58.2	60.2		
Cancer of male genital organs			34	42
Disease of prostate without secondary dx			254	25
Disease of prostate with secondary dx			255	38

Name of Procedure (1)	--Procedure Codes- ICDA-8 (2)	H-ICDA-2 (3)	AUTOGRP* DRG Code (4)	Trim** Point (5)
6 - Suprapubic Prostatectomy	58.1	60.3		
Disease of prostate			256	36
7 - Tonsillectomy and/or Adenoidectomy	21.1-21.3	28.1,.2,.5		
Hypertrophy of tonsil and adenoid			159	5
8 - Intracapsular Lens Extraction	14.5	15.4		
Disease of eye			110	13
9 - Complete or Radical Mastectomy	65.3-65.6	86.1-86.4		
Cancer of breast without secondary dx			23	20
Cancer of breast with secondary dx			24	44
10 - Arthroplasty or replacement hip	87.0-87.1	81.5-81.6		
Arthritis			294	53
Fracture of bone			348	66
11 - Cesarean Section	77.0-77.9	74.0-74.9		
Normal delivery			280	13
Delivery with complication			282	13

---

* This code number is provided as a reference to PSROs who have the AUTOGRP system available to them. See Appendix 4 for detailed list of included codes.

** Live discharges, in the indicated principal diagnosis group, whose lengths of stay exceed this value, are defined as long stays. See Appendix 5 for further explanation.

APPENDIX H

Diagnosis Related Groups Used in PHDDS Reports
Detailed List of Included Codes

Diagnosis Related Groups Used In PHDDS Reports
Detailed List of Included Codes

DRG Code	Principal Diagnosis Codes* ICDA-8	Principal Diagnosis Codes* H-ICDA-2	Principal Procedure Codes* ICDA-8	Principal Procedure Codes* H-ICDA-2
23	174.0	174.0-174.2	any surgery**	
24	174.0	174.0-174.2	any surgery**	
29	182.0,234.0, 182.9	182.0,180.0 182.9	69.2,39.1, 39.4,69.3, 72.3,47.8, 67.5,A27, 67.1	68.3,54.2, 54.0,71.4, 54.4,65.2, 68.5,65.5, 71.5,34.0, 34.1,65.1, 40.1
30	183.0,180.0, 184.1,184.0	183.0,180.9 184.1,180.1, 183.1,184.0	same as 29 above	
34	185.0-187.9	185.0-187.9	58.2,58.1, 58.3,39.1, 01.7,03.0, 56.0	60.2,60.3, 60.4,60.5
59	218.0,220.1, 220.0,221.0	218.0,220.1, 220.0,220.9, 219.9	69.2,69.4, 67.2,67.5	68.3,68.4, 65.5,68.2
74	250.0-250.9	250.0-250.7	no surgery**	

---

* Listed, in order of frequency, are all codes which represented at least 1% of the patients in the DRG in the data base used to construct the patient classification scheme. When the DRG is used in the Series 3 reports, only patients with the specific principal procedure codes also listed in Appendix 3 are included.

** Surgery is defined as any principal procedure in the following ranges: ICDA-8: 01.0-99.9, A10-A59;
H-ICDA-2: 01.0-92.9, 93.3-93.6.

DRG Code	Principal Diagnosis Codes* ICDA-8	Principal Diagnosis Codes* H-ICDA-2	Principal Procedure Codes* ICDA-8	Principal Procedure Codes* H-ICDA-2
92	300.4,301.8, 301.7,301.9, 301.5,301.3	310.5,311.9, 311.8,311.5, 311.7	not applicable***	
110	360.0-378.9	360.0-378.9	14.5,12.1, 14.4,11.7, 10.1	15.4,13.6, 15.5,17.4
121	410.0-410.9	410.0-410.9	not applicable***	
122	411.0-414.9	411.0-414.0	no surgery**	
141	437.9,437.0, 432.9,434.9, 438.0	437.0,436.0, 433.0,438.0, 438.9,434.0	no surgery**	
158	455.0	455.0-455.9	not applicable***	
159	500.0	500.0	not applicable***	
161	460.0-465.0, 470.0-474.0	460.0-465.0, 470.0	not applicable***	
165	480.0-486.0	480.0-486.0	no surgery**	
166	480.0-486.0	480.0-486.0	no surgery**	
183	531.0-534.9	531.0-534.3	no surgery**	

---

* Listed in order of frequency, are all codes which represented at least 1% of the patients in the DRG in the data base used to construct the patient classification scheme. When the DRG is used in the Series 3 reports, only patients with the specific principal procedure codes also listed in Appendix 3 are included.

** Surgery is defined as any principal procedure in the following ranges: ICDA-8: 01.0-99.9, A10-A59;
H-ICDA-2: 01.0-92.9, 93.3-93.6.

*** Neither the presence nor absence of surgery, nor the nature of the surgical procedure performed, differentiated the length of stay for patients in this group.

DRG Code	Principal Diagnosis Codes* ICDA-8	Principal Diagnosis Codes* H-ICDA-2	Principal Procedure Codes* ICDA-8	Principal Procedure Codes* H-ICDA-2
197	550.0-553.9	550.0-553.9	not applicable***	
198	550.0,551.1	550.0,550.1, 550.2,551.2	not applicable***	
204	550.0-553.9	550.0-553.9	38.2,38.3 38.4,A44, 38.7	53.0,53.2 53.4,92.3, 92.4,53.1
227	574.0-576.9	574.0-576.9	any surgery**	
228	574.0-576.9	574.0-576.9	any surgery**	
229	574.0-576.9	574.0-576.9	any surgery**	
254	600.0-602.0	222.2,600.0-602.9	58.2,58.3 56.0	60.2,60.6
255	600.0-602.0	222.2,600.0-602.9	58.2,58.3 56.0	60.2,60.6
256	600.0-602.0	222.2,600.0-602.9	58.1	60.3,60.4

---

* Listed in order of frequency, are all codes which represented at least 1% of the patients in the DRG in the data base used to construct the patient classification scheme. When the DRG is used in the Series 3 reports, only patients with the specific principal procedure codes also listed in Appendix 3 are included.

** Surgery is defined as any principal procedure in the following ranges: ICDA-8: 01.0-99.9, A10-A59;
H-ICDA-2: 01.0-92.9, 93.3-93.6.

*** Neither the presence nor absence of surgery, nor the nature of the surgical procedure performed, differentiated the length of stay for patients in this group.

DRG Code	Principal Diagnosis Codes* ICDA-8	Principal Diagnosis Codes* H-ICDA-2	Principal Procedure Codes* ICDA-8	Principal Procedure Codes* H-ICDA-2
266	612.0,621.0, 621.2,627.0, 629.0,629.2, 629.4,629.6- 629.9	612-629.9	69.2,69.4, 71.4,67.1, 71.8,67.3, 39.1,71.3, 68.4,70.7, 71.5,57.4	68.3,68.4, 70.4,65.1, 54.2,70.6, 65.3,54.5, 67.3,59.5
278	650.0	650.0	75.6,75.9, 75.7,75.0, 75.4,78.3, 76.3	73.7,72.1, 73.5,72.2, 75.3,73.1, 75.6
280	650.0	650.0	77.1	74.9,74.1, 74.8
282	651.0-662.0, 673.1	651.0-664.9	77.1,77.9, 77.0	74.1,74.8, 74.9,74.0
294	710.0-715.0	710.0-715.0	87.1,87.3, 03.0,80.3, 80.1,87.0, 80.8,04.8	81.5,81.4, 03.0,78.1, 81.6
340	808.0,820.0, 821.0,805.6, 821.2,820.2, 821.9,820.9	805.4,808.2, 821.0,808.6, 808.4,820.2, 820.0,805.8, 821.2,808.0, 820.9,821.9, 806.4	no surgery**	

---

* Listed in order of frequency, are all codes which represented at least 1% of the patients in the DRG in the data base used to construc the patient classification scheme. When the DRG is used in the Series 3 reports, only patients with the specific principal procedur codes also listed in Appendix 3 are included.

** Surgery is defined as any principal procedure in the following ranges: ICDA-8: 01.0-99.9, A10-A59;
H-ICDA-2: 01.0-92.9, 93.3-93.6.

DRG Code	Principal Diagnosis Codes* ICDA-8	Principal Diagnosis Codes* H-ICDA-2	Principal Procedure Codes* ICDA-8	Principal Procedure Codes* H-ICDA-2
348	800.0-829.9	800.0-829.9	82.5,87.1, 82.9,84.1, 81.5,82.3, 87.4,82.7, 92.1,82.1, 03.0,32.0	79.3,81.6, 79.1,79.2, 78.7,78.1, 88.4,81.5

---

* Listed in order of frequency, are all codes which represented at least 1% of the patients in the DRG in the data base used to construct the patient classification scheme. When the DRG is used in the Series 3 reports, only patients with the specific principal procedure codes also listed in Appendix 3 are included.

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CMS LIBRARY
3 8095 00007522 2